Reproductive Rights and Women's Health:
(An Anthropological Study)

Supervised by
Dr. Zahidul Islam
Professor
Department of Anthropology
University of Dhaka
Dhaka-1000, Bangladesh

Submitted by:
Most. Nasrin Zahan
Department of Anthropology
University of Dhaka
Dhaka-1000, Bangladesh

This dissertation has been prepared for the fulfillment of the Degree of Master of Philosophy in Anthropology

Department of Anthropology
University of Dhaka
Dhaka-1000, Bangladesh
January 2010

Reproductive Rights and Women's Health: An Anthropological Study

DECLARATION

This research paper is prepared to submit to the Department of Anthropology, University of Dhaka, Bangladesh to fulfill the condition of the Masters of Philosophy (M Phil) program. The material embodied in this thesis is original and has not been submitted in part or full for any other Diploma or Degree of this or any other University or Institution.

Most. Nasrin Zahan
Registration no: 110
Academic Session: 1999-2000
Department of Anthropology
University of Dhaka
Dhaka-1000
Bangladesh
Dated: 31.01.2010

University of Dhaka
Faculty of Social Sciences
Department of Anthropology

CERTIFICATE

It is my pleasure to introduce Most. Nasrin Zahan an M Phil research fellow of the Department of Anthropology, University of Dhaka has prepared her M Phil dissertation on "Reproductive Rights and Women's Health: An Anthropological Study" under my supervision.

This dissertation is submitted in partial fulfillment of the requirements for the degree of Master of Philosophy (M.Phil) in Anthropology, the University of Dhaka, during the session 1999-2000.

Supervisor

Professor Dr. Zahidul Islam
Department of Anthropology
University of Dhaka
Dhaka-1000, Bangladesh

Dedicated....

In Memory
To
My Mother

CONTENTS Page

Acknowledgement

At the very outset I would like to thank the Almighty Allah, who is the main source of inspiration and imparted knowledge in me to undertake such an ambitious task of M. Phil program without His help, it would not have been at all possible to complete this work.

In the preparation of this dissertation, I have incurred numerous debts. It is my pleasant duty to acknowledge indebtedness first to Professor Dr. Zahidul Islam of the Department of Anthropology, University of Dhaka for his inevitable supervision, and suggestions on the framework of analysis, logic of argument and style. I deeply admitted to him.

Specially I would like to thank the other teachers of the Department of Anthropology, specially S. M. Arif Mahmud, Assistant Professor of the Department of Anthropology and Professor Dr. Aminur Rahman Mozumder, Department of Soil, Water and Environment for their suggestions, supplied information, booklets, books, encouragement and experience sharing.

I am extremely grateful to my husband Mr. Sabur, who helped me during this time both academically, socially and financially. Our daughter Orpi has also been a source of support, albeit of a different nature.

I deeply express my gratitude to the entire respondents, FGDs participants and Key informants for their cooperation and statements.

I am also indebted to the Dhaka University Central Library staffs, ICDDR,B Library staffs, all librarians of the NIPORT Library for their cordial assistance and cooperation. I am grateful to my beloved father for his blessing, unfailing sacrifices and many other essential supports.

Finally, I express thanks to all of my friends for their encouragements and harmonious-relations with me.

Most. Nasrin Jahan
Date: 30th January, 2010

Abstract

Obviously it is very important for our women to realize that falling sick is not a crime. It is necessary for them to become aware of this fact and they should be encouraged to take immediately help and treatment when they become sick.

In the whole process the issue of the relation between men-women must be posed as the fundamental problematic one. The question of empowerment is meaningful in a social context where biological men also exist. A discussion only about women as if question of species production and the rearing of the child is the exclusive responsibility of women is in the final analysis belongs to patriarchal discourse.

Women's reproductive rights and freedom are key determinants of women's health and are highly influenced by women's roles in society. In the Bangladesh and other developing countries, women's reproductive health is threatened by limited access to effective contraception, knowledge, timely diagnosis and treatment of sexually transmitted infections, safe abortion, skilled maternity care, infertility treatments, and social capacity. In this 21st century medical knowledge alone, however, does not guarantee quality patient care. Effective reproductive health care also requires skilled history taking, patient education and counseling. Understanding of non-biological determinants of health and illness, including economic, psychological, social and cultural factors, is critical to ensuring quality reproductive health care for women.

Physicians and other health professionals have a key role as advocates in protecting women's reproductive health clinically, especially for underserved and vulnerable populations. But, they can not solve the socio-cultural and psychological hindrances. Like, during pregnancy, poor women in Bangladesh have to work extremely hard to survive. Daily chores typically involves cleaning home , washing entire family's cloths , collecting water, cooking as well as looking after children (typically 4- 6 children) . It is not uncommon for women to work in the field or in a factory to supplement family's income. This is especially true for poor women in urban areas. May be it is reducing and ensuring their rights by a holistic advocacy and proper health care facility.
More than half the world's population is under the age of 25, and a significant number of adolescents are sexually active. From birth through childhood and adulthood, girls and women need effective services and information to enable them to lead healthy productive lives. Boys and men also need information and services that contribute to responsible behavior and equal treatment of women and girls.

It is estimated that about 15 million teenage women give birth each year, accounting for up to one-fifth of all births worldwide. And every year, 1 out of 20 teenagers contracts a sexually transmitted disease. To reduce the rising instances of teenage pregnancy and sexually transmitted diseases among young people, the Cairo and Beijing texts call for the removal of regulatory and social barriers to reproductive health information and care for adolescents

The values that underscore reproductive rights are embodied in the oldest and most accepted human rights documents—the U S Constitution, as well as the Universal Declaration of Human Rights. At the 1994 International Conference on Population and Development in Cairo, governments explicitly acknowledged, for the first time, that

reproductive rights are grounded in already existing human rights obligations. Representatives of over 180 nations agreed that women needed to be empowered to take charge of their reproductive lives, that unsafe abortion is a public health concern, and that forced sterilization has no place in family planning efforts.

Simply speaking, reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality. When a woman is denied her reproductive rights—when she is denied obstetric care, birth control, the facts about reproductive health, or safe abortion, as the women above were—she is denied the means to direct her own life, protect her health, and exercise her human rights.

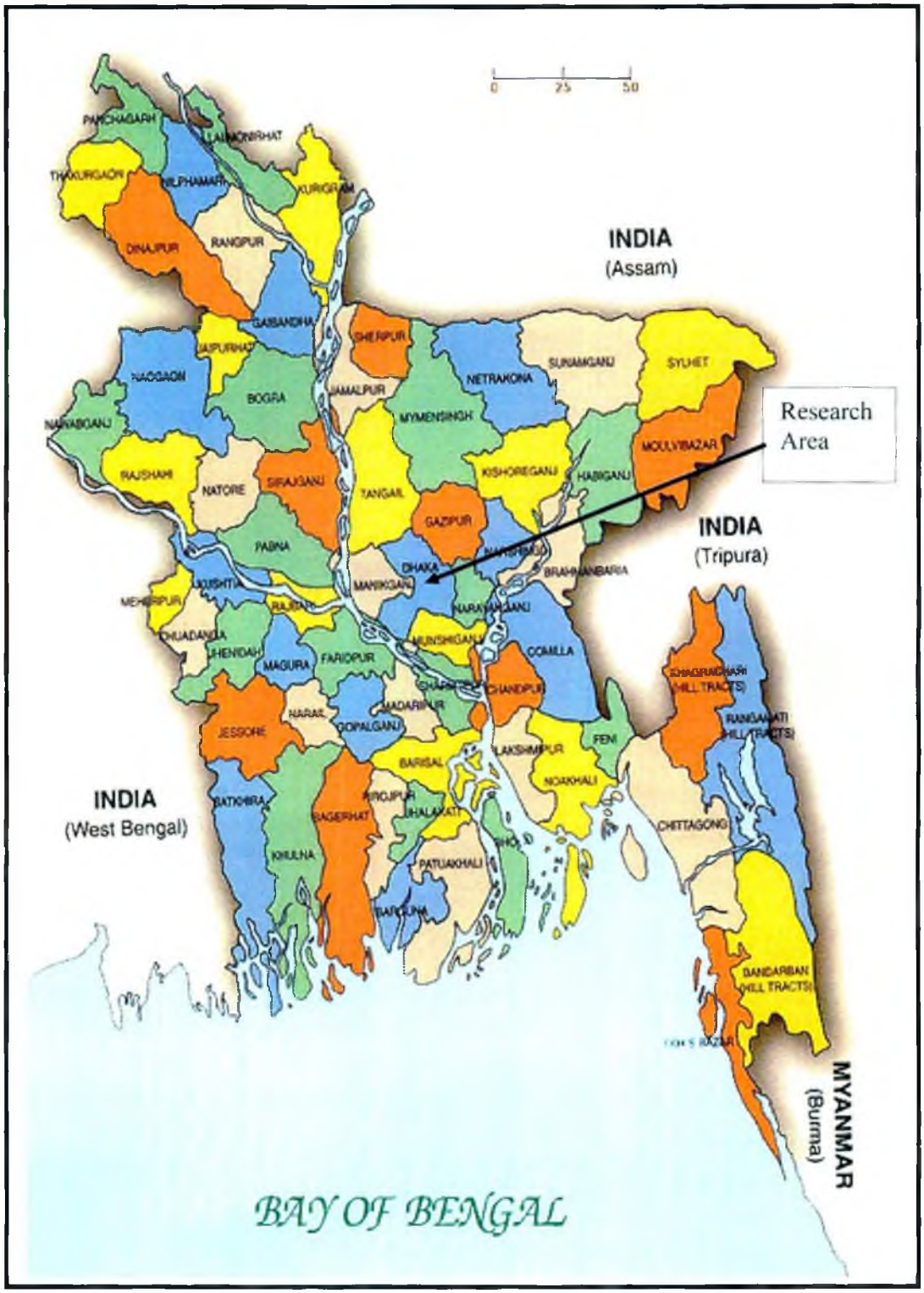
The importance of good health and education to a woman's well-being - and that of her family and society - cannot be overstated. Without reproductive health and freedom, women cannot fully exercise their fundamental human rights, such as those relating to education and employment. Yet around the world, the right to health, and especially reproductive and sexual health, is far from a reality for many women. According to the World Bank, a full one-third of the illness among women ages 15-44 in developing countries is related to pregnancy, childbirth, abortion, reproductive tract infections, and human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS).

LIST OF TABLES

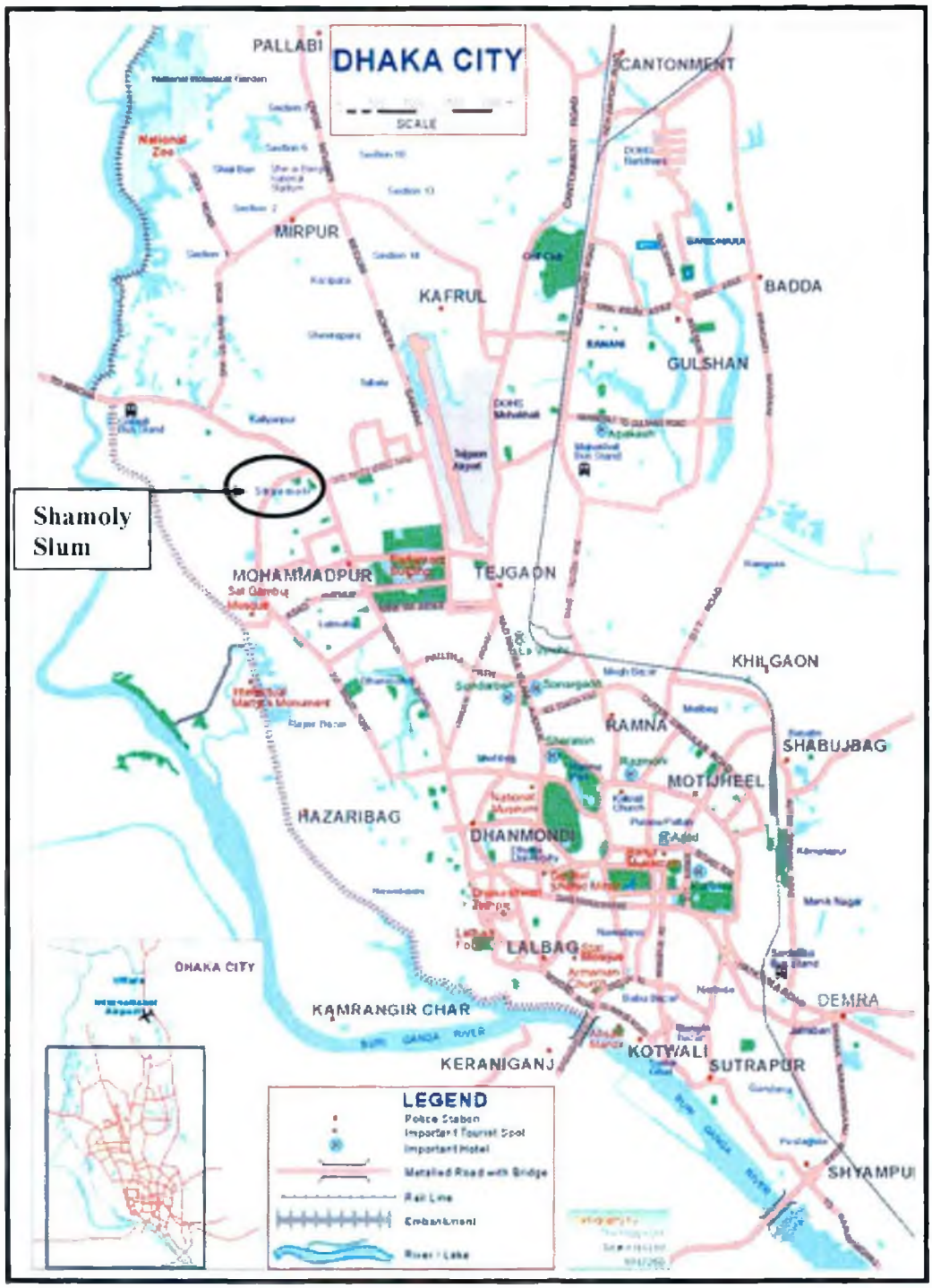
LIST OF FIGURES

LIST OF PHOTOGRAPHS

Map-1: Research Area in the Map of Bangladesh



Map-2: Location of Shamoly Slum in Dhaka City



LIST OF ABBREVIATION

AHI	Assistant Health Inspector
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BBS	Bangladesh Bureau of statistics
BDSH	Bangladesh Demographic and Health Survey
BIRPERHT	Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies
BRAC	Bangladesh Rural Advancement Committee
CDR	Crude Death Rate
CPR	Contraceptive Prevalence rate
FHI	Family Health International
EPI	Expanded Program on Immunization
FPMCH	Family Planning Maternal and Child Health
FWV	Family Welfare Visitor
GDP	Gross Domestic Product
GOV	Governmental Organization
HIDV	Human Immune Deficiency Virus
HPSP	Health and Population Sector Program
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Devices
MR	Menstruation Regulation
NGO	Non Government Organization
NRR	Net Reproductive Rate
PNC	Postnatal Care
RTI	Reproductive Tract Infection
STDs	Sexually Transmitted Diseases
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UN	United Nation
UNFPA	United Nation Population Fund
UNICEF	United Nation Children Fund
US AID	United State Agency for International Development
WHO	World Health Organization

CHAPTER ONE
Introduction

CHAPTER ONE
Introduction

1.1 Introduction

Bangladesh is a developing country. It has the highest population density in the World. Most of them are poor and illiterate. Most of them are not conscious to their health where women, mostly poor women, are much neglected. It is known to all that most of the members of a household are not interested about the health of their women female member unless her condition is near to death. But women's good health is the pivotal factor in many of the circular relationship with development.

In Bangladesh about 96 percent of deliveries take place at home; as a result, complications related to pregnancy and child birth continue to be the leading case of mortality among women of reproductive age. (Khan et al, 1986 and Kamal et at,. 1993). Every year about half a million of women die of pregnancy related causes, with 99 percent of them in developing countries (ICPD, 1994). One of the five major causes of death in women of reproductive age in many parts of the developing world is complication due to abortion. It has been estimated that abortion related deaths account for a minimum of 23 percent of all maternal deaths around the world (Royston and Armstrong et al, 1989). Two out of five abortion procedures are unsafe, and one out of every 400 women who undergo an unsafe abortion dies. Fourteen percent of all maternal deaths in South-Asia can be attributed to unsafe abortion procedures.

The high maternal mortality rate in Bangladesh can be reduced, partially through changes in antenatal care practices in the rural areas. Result of survey show that most rural mother does not receive antenatal care. The Government of Bangladesh has been striving to provide maternal health care to rural women through the national health and family planning program. The government health center, such as Thana Health Complex and Satellite Clinics (SCs), provide maternal and child health services to the rural population free of charge. However, the use rates of these health centers are very low, resulting in high maternal and neonatal mortality (Juncker, 1994).

Some key issues in reproductive health that continue to challenge the Bangladesh Health and Family Planning Program are in the following areas: Contraception, abortion, fertility/ infertility, reproductive tract infection (RTI)/ STD, maternal mortality and morbidity and infant and child mortality.

In each of these key areas of reproductive health, important research and programative work is underway. More research is still needed, however concerning men and women's awareness and knowledge of reproductive health issues, their sexual practices and health seeking behavior, provider knowledge and practices, current prevalence and trends in RTIS / STDs, determinants and health consequences of various reproductive health behaviors, and on the issues of quality of care and sustainability of various reproductive health services in Bangladesh.

Therefore, the present study titled "Reproductive Rights and Women's Health: An Anthropological study" is an effort to uncover the underling meaning of reproductive health rights and existing status of this among those people living in the slums of urban Dhaka. It has been observed that they are the most vulnerable people and lack proper knowledge and

understanding of the right based issues on reproductive health. Moreover, it is women who are the most sufferers in Bangladesh and particularly in the slum areas where basic human needs are inadequate. So from an anthropological point of view if women are ensured and equipped with necessary knowledge, information, equipments, facilities and related other things, they will be shifted from their vulnerable status. It is expected that the present study would be able to provide necessary information for policy issues and recommendations and also facilitate the other fields of study.

1.2 Objective of the study

Broad Objective

The major objective of the present study is to find out the existing knowledge of the reproductive right and women's health and to give a comprehensive picture of women's health related issues focusing the ways in which people exercise their reproductive right and sexual behavior.

Specific Objectives

The specific objectives are given below-

1. To gather knowledge about the reproductive rights and women's health consciousness of people in Bangladesh.
2. To analyses the factors which influence women's health behavior in different ways.
3. Find out what people's beliefs are about reproductive rights and how these beliefs in turn influence their reproductive choices and women's health behavior.
4. Put forward policy recommendations for maintaining reproductive health status of couples and enable them to exercise reproductive rights.

1.3 Rational of the study

Half a million women-wives, daughter, sister, mothers of families, pillars of the community-die each year from causes related to pregnancy and childbirth in the world. Only tiny fractions (5,000) of those 500,000 deaths take place in developed countries. All the rest occur in developing countries, where they are responsible for one-fourth to one-third of all deaths of women of childrearing age. Over half of all maternal deaths occur in South Asia, predominantly in Bangladesh, India and Pakistan. Africa accounts for another 150,000 of the total.

During the last few years we have witnessed various agencies and the government taking considerable steps for reproductive health programmers. There have been several studies on women's status, education and employment in relation to their fertility. These have often reached only partial conclusion because yet the vast majority of women still delivery their babies at home, often in unhygienic conditions causing needless morbidity and mortality for both the mother's and infants they bear. Many programs in the reproductive health agenda are just beginning to receive attention though there is seminal data which indicates possible future directions. In this context the present study endeavors the new avenue for the formulation of hypothesis in future.

1.4 Conceptual Framework

Some of the terms used in study are needed to be conceptualized and defined which reveal the researcher's understandings and conceptualization of the terms integrated to reproductive rights and women's health

Health

To be health is a basic human right of all people. Physical, emotional and mental well-being leads to sufficient energy, physical strength and harmony in life, allowing people to be productive and deal creatively with the development of society, the family and themselves. Having control over one's health means possessing the knowledge of what needs to be done in order to be health the money with which to purchase health care, and the capacity to make the necessary decisions. Good health is a primary condition for development. Without it, life is more painful, slower and happiness is more elusive. (Asian and Pacific Women's Resource and Action Series Health, 1989) The World Health Organization (WHO) defined, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Preamble to the Constitution of the World Health Organization, 1946). According to WHO's Ottawa charter, Public health.....a concept for everyday life…emphasizing social–peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity and personal–physiologic–resources".(http://medicaldictionary.thefreedictionary. com/health). The present study has been designed to understand health as a mental, physical and social well being of the women as well as the psychophena of the people related to this study. This, in other words, focuses on the reproductive health of the women under study.

Sexual Health

Sexual health indicates all reproductive health areas like – maternal care, prevention of abortion, RTIs, STDs, HIV, AIDS; infertility and prevention of harmful practice. Now-a-days STDs and HIV/AIDS are the important factors which affecting the sexual health of couples. The incidence and prevalence of Traditional STDs e.g. gonorrhea, syphilis has declined some what; there has been an increase in infections associated with various sexual transmitted virus. These infections are more difficult to identify, treat and control and can cause serious complications or chronic ill health. The World Health Organizations (WHO) definition of sexual health is "a state of physical, emotional, mental and social well-being related to sexuality; not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be protected, respected and fulfilled".

This is thought to be one of the most important aspects of the present study where the rights of women are to be addressed. Because every individual human being has the right over sexual exercise, but the scenario for women in Bangladesh is very poor. At this point this study tries to unfold the inner aspects of sexual health considering physical, mental and social well being.

Women's Health

The issue of women's health cannot be understood without a board definition of health related to women's role and position in society, particularly in the institution of the family. Women in the Asia and Pacific Region active in the area of health have adopted a broad approach to women's health problems and issues. It is recognized that the roots of disease and health hazards are in the social and economic structures of our society and until and unless the socio – economic condition changes, women will continue to suffer. The state of women's health in the region is generally poor. The actual health status varies from country to country, and within countries, according to class, race, occupation and location of women at different level. The length of life of women as an overall indicator of health, for example, varies enormously. The average Japanese woman now lives to 80 years, almost the same as the life expectancy for Australian women of 79 years. Women of Nepal, Bhutan, Bangladesh and Democratic Kampuchea, however, die by their late forties. Women in Pakistan reach 50 years of age only, compared to China where women live to 76 years on an average (Asian and Pacific Women's Resource and Action Series Health, 1989).

This concept is also crucial to the present study. As already mentioned, if family is an institution then every member of the family has a right to uphold their health. Considering the status of women, they suffer most in Bangladesh and in many instances do not get adequate food and nutrition despite their heavy duty to the family. Therefore, it is high time to consider women's health as a separate entity.

Reproductive Health

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant" (ICPD) in 1994.

Reproductive 'health' is defined in paragraph 7.2 of the Program of Action of WHO in 1994 as "a state of complete physical, mental and social well-being ... in all matters related to the reproductive system", which "implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

UNFPA Lao PDR considers the following activities and services as integral to government's responsibility to ensure the reproductive health of citizens:

- Family planning, education, counseling and services;
- Education and services for antenatal, safe delivery and postnatal care and healthcare for infants and women;
- Prevention and management of abortion complications;
- Treatment of reproductive health conditions;

- Prevention and treatment of reproductive tract infections and HIV/AIDS;
- Information, education and counseling on human sexuality and responsible parenthood.

Therefore, is this study an attempt has been made to understand the situation of those women who are able to reproduce and have fertility as a vital entity to their overall health condition.

Reproductive Rights

"Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individual to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community". (International Committee on Population and Development Plan of Action, paragraph 7.3, 1996).

The International Conference on Population and Development (ICPD), 1994 recognized women's rights to reproductive and sexual health as being key to women's health. The basis for these rights can be found in various articles of the Convention on the Elimination of All Forms of Discrimination against Women. Rights to reproductive and sexual health include the right to life, liberty and the security of the person; the right to health care and information; and the right to non-discrimination in the allocation of resources to health services and in their availability and accessibility. Of central importance are the rights to autonomy and privacy in making sexual and reproductive decisions as well as the rights to informed consent and confidentiality in relation to health services.

The ICPD in 1994 referred to the term "reproductive rights" as embracing "certain human rights that are already recognized in ... international human rights documents and other consensus documents". The most mentionable "consensus documents" are the Universal Declaration of Human Rights, and the Declaration and Program of Action of the World Conference on Human Rights, Vienna, June 1993.

The human rights already recognized in "international human rights documents" include "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" as guaranteed by Article 12 of the International Covenant on Economic, Social and Cultural Rights (1964) (ICESCR). Other health-related human rights fall within the scope of certain fundamental freedoms protected under the International Covenant on Civil and Political Rights (1964) (ICCPR). These include the right to life, the right to liberty and security of the person, and the right to privacy, to mention just a few. In addition, the Convention on the Elimination of All Forms of Discrimination against Women (1978) (known as CEDAW and hereinafter referred to as the Women's Convention) is particularly pertinent to the enjoyment of sexual and reproductive rights.

Reproductive rights, according to the ICPD (1994), "rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the

highest standard of sexual and reproductive health." The language is taken from Article 16(1) (e) of the Women's Convention, which states that States Parties shall ensure on a basis of equality of men and women: "the same rights to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights."

Reproductive rights, according to the ICPD, also include the right "to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents." This aspect of reproductive rights can also be derived from the Women's Convention. (International Conference on Reproductive Health, Mumbai, India, 1998). Reproductive Rights also means a woman should have the power to decide and control her own bodies and reproductive behavior.

The present study correlates the concept of reproductive behavior as most of the women in Bangladesh have no right and say to their sexuality and decisions regarding what can be done in time of child birth.

Sexual Rights

According to Beijing Platform for Action in 1994 (paragraph 96) sexual rights is, "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences".

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to:

- Seek, receive and impart information in relation to sexuality;
- Sexuality education;
- Respect for bodily integrity;
- Choice of partner;
- Decide to be sexually active or not;
- Consensual sexual relations (not be forced to have sex through the use of violence or non-physical force);
- Consensual marriage;
- The highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services;
- Be protected from the risk of disease such as HIV and other STDs;
- Decide whether, and when, to have children;
- Pursue a satisfying, safe and pleasurable sexual life.

"The responsible exercise of human rights requires that all persons respect the rights of others."(Working definition of World Health Organization in 1996).
This concept has been taken in this study to clarify the status of equal relations of men and women regarding their sexual rights and sharing through mutual respects.

Health-Related Rights under the Women's Convention

As already mentioned, article 16(1)(e) of the Convention guarantees the right to decide on the number and spacing of children, but that is only one of the articles that address women's rights in relation to health. Article 12 is central. It formulates (in paragraph 1) States Parties' obligation "to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning." It further stipulates (in paragraph 2) their undertaking to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

It should be noted that the Women's Convention is the only one of the six human rights treaties in the United Nations system to mention family planning. In addition to the aforementioned articles, the right of access to specific educational information and advice on family planning is guaranteed under article 10(h). And article 14(b) specifies, in particular, the right of women in rural areas to have access to adequate health care facilities, including information, counseling and services in family planning. The Convention also refers to women's right to protection of health and to safety in working conditions, including "the safeguarding of the function of reproduction", in article 11(1) (f).

Many other provisions of the Convention have an implicit or indirect bearing on women's rights in relation to health, some of which have been explicated in the General Recommendations of the CEDAW Committee in relation to female genital mutilation; sexual violence; HIV/AIDS; and reproduction. The present study tries to cover all these issues to realize the existing situation and practice in Bangladesh.

Sexuality

Sexuality is a central aspect of human being throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors." All these are of importance in this study and help to design the overall aspects of sexuality in Bangladesh.

Sexuality and Gender Relations

"Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body; require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour. Responsible sexual behavior, sensitivity and equity in gender relations, particularly when instilled during the formative years, enhance and promote respectful and harmonious partnerships between men and women." (ICPD Plan of Action in 1994" paragraph 7.34). In terms of gender women are mostly neglected to have voice and rights of sexuality in Bangladesh. Therefore, this is taken to understand the different dimensions of views towards gender and sexual relations.

Safe Motherhood

The main problem of maternal mortality is perhaps the most alarming index of the state of reproductive health in the world. Safe motherhood means to protect a pregnant woman by five major issues and other related causes which cause pregnancy related deaths. Five major issues are abortion, eclampsia, infection, hemorrhage and obstructed labor. It is estimated that a quarter of all pregnancies are high risk. Maternal morbidities are widely prevented and it is believed that vesicovaginal fistula, chronic pelvic infection, secondary in fertility are quite common morbidities.

The promotion of the responsible exercise of above mentioned reproductive rights for all people should be the fundamental basis for government and community-supported policies and programs in the area of reproductive health, including family planning. As part of their commitment, full attention should be given the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.

In Bangladesh, most of the mothers suffer from various diseases for which they need proper care. This is deeply rooted responsibility of the male partner and other family members. Many of the mothers also die due to the lack of care. Therefore, safe motherhood is a slogan and crucial aspect during a mother's pregnancy and has been given high importance in this study.

CHAPTER TWO
Methodology

CHAPTER TWO
Methodology

2.1 Research Methodology

Research methodology helps solving every single problem concerning the research work. "Methodology" may be used to refer to theoretical discussions concerning the entire research proposal including the forms of thought of the research, aims and objectives of the research, application of research methods, etc. Methodology is also often used in a narrow sense to refer to the methods, techniques or tools, etc. employed for the collection and processing of data. But in a broader sense methods or techniques are one of the components of methodology. Thus the success of any research works, whether in anthropology or in any other discipline, heavily depends upon the proper utilization and understanding of research methodology used in practice (Jha, 1994: 150-52).

With a research problem, a theory of social or cultural interaction or behavior, and a variety of conceptual guidelines, etc. a method within research methodology is a fundamental phenomenon to make an anthropological research easier to conduct. Thus before asking the first question in the field the researcher begins with a problem, a theory or model, a research design, and in general, a specific data collection technique or methodology for research work (Fetterman, 1989: 11).

2.2 Research Methods in Urban Anthropology

The research methods that are used in anthropology for a long period of time had greater view and application to the study of rural societies. But the question that can be asked is whether the similar kind of methods or research in rural societies can also be applied in urban societies as urban societies are more complex and heterogeneous, where as rural societies are quite simple and homogenous in nature (Basham, 1978: 9). Therefore, before examining the research methods applied in the present study, some ideas are taken on urban anthropology, its perspectives and views for research.

Urban anthropology, which has theoretical (basic research) and applied dimensions, is the cross-cultural and ethnographic study of global urbanization and life in cities. Urban anthropology, however, has foreground forms and principles of human organization kinship in order to depict the full complexity of social life towns and cities (Sannjek, 1990: 151). The hallmark of anthropological research method is participant observation and holism in the life of community which demands the researcher to live among the people he studies and participate as fully as possible in their daily lives (Basham, 1978, p.25). By its very nature the city makes the holistic tradition of participation-observation impossible because the size and diversity of even the smallest city makes it impossible for the anthropologists to know each inhabitant except in the most superficial manner (Ibid, 1978: 299-300).

In recent years a quite revolution is seen in the field of anthropological, social sciences as well as in the development research where a new appreciation for qualitative research has emerged among different scholars of different disciplines. These qualitative research methods have become increasingly important modes of inquiry for social sciences and applied anthropology such as education, regional planning, health and management. But recently in the field of development research and also in the field of urban anthropological research a significant

change is seen where both qualitative and quantitative research methods are widely used because today anthropologists are more flexible in collection of data and in the implication of data collection technique or research methods.

Again, anthropologists working in urban and complex societies may wish to improve their descriptions through use of historical, demographic, and survey techniques; but they must retain intensive indepth interaction with small groups to direct inquires and flush out their conclusions. Stanley R. Barrett (1989: 7) stated that in terms of methodology, the reorientation of the discipline will mean using computers, statistics, sampling procedure and questionnaires.

2.3 Methods Used in the Study and Technique of Data Collection

One of the major problems of the anthropologists working in cities is not really methodological, but theoretical and conceptual; hence anthropologists must search for "most significant context" within which to relate their particularistic cultural studies on the whole of the world's political economics system (Gmelch & Zenmer; 1988: 149). However, the present study has been conducted on the phenomenon of urban life (reproductive health) and hence different methods and techniques have been used in the collection as well as analysis of data. The methods and techniques used for data collection for this study are discussed below. It is mentionable that both qualitative and quantitative methods have been used here.

Formal and Informal Observation

Both formal and informal observation methods have been used in the research. In terms of formal observation the criteria, behavioral and general presence as well as activities of the people has been observed by identifying and selecting the study area. Whereas with the informal observation these people are observed with an informal way. In this case the samples are randomly selected, observed with no predetermined view and process and they were being left to be watched with their normal activities without interfering into their work.

Fieldwork and Participation

It is the method of fieldwork which is the hallmark of research for anthropologists and which means working or mixing with people for certain period of time in their natural settings. Thus the fieldwork method has been used intensively and with great importance to conduct the present research successfully. Participation is a method which has been quite successfully used in this research work. It has been used as an anthropologist to take more indepth view from the field and to be more integral part of their culture.

Structured and Unstructured Interviewing

Both structured and unstructured interviewing methods are applied in this research. In this case a questionnaire with some selected questions has been used interview the samples and also used the unstructured interviewing by mixing with the interviewers with no formal discussion and set of questions which helped to get more underlying information about the problem.

Use of Fieldwork Diary

A fieldwork diary has been used in the study to note every of the credentials, mistakes as well as information and notes done or collected during field work in the field. This diary has been living partner rights from the beginning to end of the fieldwork to overcome from sever loneliness, fear and emotion.

Use of Camera (Photograph)

In this visual and technology world of communication the use of camera in collecting photographs on several subjects of slum dwellers and its related issues is a live presentation of information and data.

Use of Internet

Up-to-date data and information regarding different issues of reproductive right and women's health were collected during the study both form Bangladesh and from around the globe through Internet browsing which helped to enrich the study.

2.4 Sources of Data Collection

Data collection is one of the major tasks in conducting the research and during the field work. Different kinds of sources can be used in this respect. However, in this research both primary and secondary sources of data have been used. Primary sources of data collection for this research are those that have been directly obtained from the field and through the close contact with the responding people during the field work. Besides these data have also been collected from the secondary sources that is, from various books, journals, articles, statistical information, daily newspapers, magazines etc. to support the research work, taken together both primary and secondary sources of data collection worked as fuel to keep the machine of the study running, grounding and validating.

2.5 Techniques of Data Analysis

To make the findings of the research more fruitful one of the mo0st important task of the researcher is to configure out and organize the new data collected from the field and then to analyze them in a more definite and figurative way. To have a meaningful analysis from the data collected from the respondent considerably they are needed to be properly coded, transferred and processed through a machine, usually a computer and then these are re-organized with the help of statistical tabulation and analysis. These are all the steps and techniques that have been taken into account in the present study. To understand the specific phenomenon of the study the statistical analysis is confined with frequency distribution, graphical presentation and percentage. Based on both primary and secondary sources of data collection the result has been interpreted with a fruitful qualitative and quantitative analysis of data.

2.6 Sample Size

The sample size of this study is 200 covering 100 female and 100 male respondents of the slum. They have been selected purposively keeping in mind the objective of this study. This is

done in such a way so that the selected sample could address every aspect regarding reproductive rights and health status of women in a more organized way.

2.7 Selection of the study Area

The present research work is based on the slum of Dhaka city focusing the reproductive rights and women's health. In doing so specific area has been selected for the study and it is a slum situated at *Shamoly* of urban Dhaka. Because the people, particularly women, living in the slum areas are more vulnerable considering reproductive rights and health in Bangladesh. Moreover, people living in the slum are poor and have come from various regions of Bangladesh. They not only lock of education but also the basic human needs to survive among which the factor of reproductive health is the major one. In addition, the slum of *Shamoly* covers the interests and objectives of this study.

2.8 Criteria for the Selection of the Study Area

In terms of criteria for the selection of the study area some of the most rationale and important points have been taken into consideration. For the purpose of the study it has been carefully maintained that the selected study areas should fulfill the objectives of the study and should also support in collecting reliable and meaningful data, easy access to the study area, time, budget etc. However, the criteria for selection of the study area can be mentioned in following terms.

1. In selecting the study area it is maintained that the area for the study must support the objective of the study taken into account.
2. Easy accessibility to the study area is also kept in mind.
3. Time and money or budgets are the two vital factors in selecting the area. Because the study had to be conducted with limited self budget and within a short period of time. So the more the study area is close to the researcher's easy access the more the chance is to complete the task properly with no fund provided and within the bound time period.
4. Finally and most importantly the area is selected particularly for the issue that the reproductive rights and health status of women, in particular, are more vulnerable in the slums of the Dhaka city and people living here are not only poor but also have limited access to every aspects of basic human rights.

2.9 Time framework

In total Researcher has spent near about 10 months for data collection. First 4 (four) months were spent required about health and reproductive health programme issues which conducted by the NGOs and Government and determine survey assistant, pre-testing and finalizing questionnaire. And next six months were spends for intensive fieldwork- conducted 100 couples interviews, data cleaning and re-checking of the data.

2.10 Pains and Pleasures of Fieldwork

One of the most significant characteristic features of any anthropological research is to complete the study by conducting fieldwork. It helps in shaping the design set for the research to be carried out.

In the present study after getting the primary preparations of collecting materials and several other issues in regard to the problem of the study at hand the researcher went on to work in the field to conduct the research successfully. Some of the experiences from the field are discussed here.

The fieldwork for the present study took the time period from the 1 July- the 30 August 2008. The researcher went to the field everyday and collected data from study area. A route has been maintained during the fieldwork and the time period taken for collecting data and getting interview of the unit of the study. But it appeared quite problematic for the researcher almost everyday during fieldwork to get close to them because of their unwillingness to speak which sometimes put the researcher in disgrace.

Government official are always in a state to make harassment in our country. In this case it took few terms to collect information from the officials of the secretariat.

Another problem faced by researcher was that in most of the cases the respondents asked various questions such as " what is the intention of this research, what will be the outcome, what is the benefit of the researcher, does the researcher work for any NGO, how this can be an academic study, etc. All those questions got the researcher into more interest and attention to the study and overcome these few problems with suitable analysis as required.

Alongside these painful experiences some pleasuring and encouraging field experiences were also gained by the researcher. It is the curiosity of the respondents in general that encouraged the researcher to continue with the work more aggressively. Both in case of definite questionnaire and formal interview as well as in case of informal interview or gathering they communicated and behaved well and talked very lively about different aspects of reproductive rights and health issues. Their live and joyful participations helped the researcher a lot to understand the facts.

However, this is a unique anthropological study and both pains and pleasures in the field gave the researcher some indepth analytical capability and interesting views. In general these fieldwork experiences helped the researcher to acquire knowledge from the field, to learn about the credentials and mistakes and to make the research work more reach and spirited where without their help and criticize these could not have been possible.

2.11 Limitation of the Study

Urban life is complex and heterogeneous is nature. It consists of different types of people and is a vast array of cultural integration. Dhaka is a mega city and the urban area is comprised of a vast geographical setting where the city has expanded and still expanding to wider spaces. This is why only one slum has been taken for study. Because it is not possible to integrate the people of all the areas which is why the selected area has been taken into consideration.
Another limitation of the study is that some instances people have not unambiguously talked about several grounds. In other words, they hesitated to express their real life feelings which put some pictures of their cultural attitudes out of scene. However, despite some of those limitations there has been no effort and sincerity left by the researcher to the present study which made it more valid and maintains its objectivity.

CHAPTER THREE
Literature Review

CHAPTER THREE
Literature Review

Literature review is a very important part of report writing. In this regard George J. Mouly identified that "the review of the literature is an exacting task, calling for a deep insight and clear perspective of the overall field". In this content an attempt has been made to provide a comprehensive picture of reproductive rights and women's health related problems encountered by women of Bangladesh through receiving existing literatures.

Masder F. Masudi (1995) *in Islam and Women's Reproductive Rights* has used the concept of reproductive rights (RR) of women from a religious point of view. UNFPA and WHO have taken a number of initiatives in the form of projects for awareness building on reproductive health (RH). But the question remains is there any Islamic view on the practices of reproductive health? Bangladesh is a second largest Muslim country in the world. In general peoples of Bangladesh are doing their personal family life guidance by ethical and spiritual principles. This book has unfolded the messages on women's RR from the Islamic perspective. To present a complex and controversial subject like RR to religious Muslim women, particularly to those who are uneducated, is of course an uphill task. It stated that one of the main reasons for the persistent inequality between men and women is lack of knowledge about what Islam dictates on women's rights with the myth that it is the principal obligation of women to gratify men sexually. Rather showing concern for women's security, complementarities of men and women is to be considered for a healthy and harmonious family life. What the Holy Quran and Hadith say about RR and RH have been presented in plain language in the form of dialogues and that has made the presentation more engrossing.

Written in a story telling fashion in contrast to the conventional descriptive way, the book reveals truths and messages through stories. Islam advises marriageable adults to go for responsible choices. The reference to Surah Lukman (31:14) regarding suckling the baby is worth noting for everyone, including imams of mosques who are to propagate the messages to the devotees. The argument that reproductive decisions are the outcome of joint deliberations of the husband and wife are hinted at through various instructions put in various Quranic verses. This contains valuable guidance on the choice of appropriate conjugal partners how to give birth to normal babies, birth control practices, how to handle obstetric complications and divorce modalities from the Islamic perspective. In conclusion the book discusses fair play vis-à-vis man-woman relations; it affirms that no partner is superior to the other; husband and wife should be treated as equal partners in decision-making regarding conjugality and child birth.

In *Reproductive Health in Bangladesh: A Sectoral Review* Nancy J. Pie-Pelon (1996) red for UNFPA. In order to provide quality reproductive health programmers, UNIPA assistance will make a contribution to the achievement of two important goals of the Cairo process. First, that all countries should take steps to meet the family planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and to related reproductive health services which are not against the law (ICPD programme of Action: 7, 16). And second, those countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal morality by one half of the 1990 levels by the year 2000 and a further one half by 2015" (ICPD programme of Action: 8, 21). The UNFPA Guidelines state that "UNFPA support can be provide for the following information and service delivery

component of reproductive health programs. The full spectrum of family planning information and services, including counseling and follow-up services, aimed at all couples and individuals prenatal delivery (including assisted delivery) and post-natal care of mothers at the primary health care level with appropriate referral for the management of obstetric complications: prevention of abortion, management of the consequences of abortion and post-abortion counseling and family planning prevention of reproduction tract infections (RTIS) including STDs and treatment of symptomatic infections, the UNFPA guidelines serve as an outline for future programming, as well as a challenge to expand beyond their historical family planning information and services programs to ones which encompass the wider agenda of reproductive health.

Reproductive Health in Rural Bangladesh: Policy and Programmatic Implications is a study by Thomas T. Kane, Barkat-e-Khuda & James F. Philips (1997). The result of the study indicate that there is a strong need to focus strategic measures upon the increased use of health care facilities, such as the THC, H & FWC and SC. Emphasis should be given to the IEC activities of the national health and family planning programme so that the community, particularly the poor and uneducated women become aware of the need for regular antenatal check-ups and safe delivery by competent health personnel. Trained TBAs should be linked with the health and family planning service delivery system at different levels to ensure their utilization. Female education should also be promoted.

The result of the logistic regression analysis show that certain demographic, socioeconomic cultural and programmatic factors are significantly associated with the antenatal care-seeking behavior of rural women. The poorer women were less likely to seek antenatal care or to consult qualified persons (e.g. doctor, nurse and paramedic) for antenatal care. This was as expected in rural Bangladesh, since consulting a qualified person generally involves some cost on the part of the client. Moreover, although antenatal services are provided free of charge from the Government health canters, the clients are often required to spend money for transportations and, in many cases, for buying medicine, (ICDDR,B, center for Health and population Research, July 1997).

The overall objective of the study *Integration of Reproductive Health Services for Men in Health and Family Welfare Centers in Bangladesh* (2004) was to increase men's access to and acceptance of reproductive health services at Health and Family Welfare Centers (H&FWCs) in Bangladesh. The study was conducted in collaboration with the National Institute of Population Research and Training (NIPORT), the Directorate of Family Planning, and the Population council. NIPORT is a national research and training under the Ministry of Health and Family Welfare. The Directorate of family planning provides reproductive health services including family planning at the union level (the lowest administrative unit, covering a population of 30,000 to 50,000) through its 3,700 HFWCs. These centers offer curative and preventive services to mothers and children. Each HFWC is staffed by a family welfare visiting (FWV) and a sub-Assistant community Medical officer (SACMO). They are supported by five to seven families' welfare Assistant (FWAs). FWVs are traditionally women who have received 18 months of basic training in reproductive and child health care and provide family planning and maternal and child health (MCH) services. SACMOs, on the other hand, are predominantly men who have three years of basic training in reproductive health, child health care, and basic medical services. They provide general health care, child health care, and treatment for minor ailments to both male and female clients. The study activities began in November 2008 and were completed in December 2002. The study was carried out in the four major divisions of Bangladesh; Dhaka, khulna, Rajshahi and Sylhet. The interventions were tested in twelve

government health facilities. The primary intervention groups in the study were men of reproductive age and grassroots-level service providers.

It also revealed that men do suffer from various reproductive health problems. Nevertheless, they do not use the services provided by HFWCs. Even for general health care, the majority of men do not seek service from HFWCs. One of the possible reasons may be the general perception that HFWC service are only for women and children, not for men. To address this issue, the population council, in collaboration with NIPORT and the Directorate of Family Planning, attempted to reach men through existing government staff at HFWCs in 1997. A small scale study conducted in one HFWC yielded promising results but the findings were inconclusive for making policy recommendations. The study shaved that no scalpel vasectomy (NSV) and condom use increased considerably in the intervention area. FWAs have also shown potential to reach males with BCC materials.

Bangladesh Demographic and Health Survey (2007) was the fifth nation-level demographic and health survey designed to provide information on demographic and maternal and child health in Bangladesh. The BDHS included a household survey of ever-married women age 10-49 and ever-married men 15-54. The BDHS also included a community questionnaire and a health facility and service availability questionnaire administrative during the listing of household to informants in communities around the sample points from which the households were selected. The 2007 BDHS was conducted under the authority of the National Institute for Population Research and Training (NIPORT) of the Ministry of Health and Family welfare. The survey was implemented by Mitra and Associates, a Bangladeshi research firm located in Dhaka.

As with prior DHS surveys, the main objective of the BDHS 2007 is to provide up-to-date information on fertility and childhood mortality levels, fertility preferences; awareness, approval and use of family planning method; maternal and child health including breast feeding practices, nutrition levels and newborn care; knowledge and attitudes towards HIV/AIDS and other sexually transmitted infections (STI); and community level data on accessibility and availability of health and family planning services. This information is intended to assist policymakers and program managers in evaluating and designing programs and strategies for improving health and family planning services in the country.

Achieving the Millennium Development Goals for Health and Nutrition in Bangladesh: Key Issues and Interventions—An Introduction is a study by David A. Sack (ICDDR'B, 2008). This study highlights the millennium development goals indicators in the basis of presents and governance system of health sector in Bangladesh. Achieving MDG 1, 4, 5, and 6 will be a challenge for Bangladesh. This will require a coordinated effort to improving health services for mothers and children, improving nutritional status, reducing the burden of infectious diseases, and using modern technologies in a cost-effective manner. This volume is intended to stimulate discussion on how to improve these services most effectively.

Woman and World Development Series is a study (1993) developed by the joint UN/NGO Group on women and development and makes available the most recent information, debate and action being taken on world development issues and the impact on women. The aim of each title is to bring women's concerns more directly and effectively into the development process and to achieve an improvement in women's status in our rapidly changing world.

The Group was established in 1980 to organize the production and distribution of joint UN/NGO development education materials. It was the first time that United Nation agencies and Non Governmental Organizations had collaborated on this way and the Group remains a unique example of corporation between international and non-governmental institution. When the first joint United Nations information committee/Non governmental organization (JUNIC/NGO) publication on women, health and development appeared in 1981, its tone was one of cautions optimism. Although the state of women's health, especially in developing countries, given rise to many concerns, there were certain grounds for optimism.

'Reducing Maternal Mortality and Improving Maternal Health: Bangladesh and MDG 5', is a study of ICDDR'B (2008), conducted by Marge Koblinsky, Iqbal, Elahi Chowdhury and others. The study shows that Bangladesh is on its way to achieving the MDG 5 target of reducing the maternal mortality ratio by three-quarters between 1990 and 2015, but the annual rate of decline needs to triple. Although the use of skilled birth attendants has improved over the past 15 years, it remains less than 20% as of 2007 and is especially low among poor, uneducated rural women. Increasing the numbers of skilled birth attendants, deploying them in teams in facilities, and improving access to them through messages on antenatal care to women, have the potential to increase such use. The use of caesarean sections is increasing although not among poor, uneducated rural women. Strengthening appropriate quality emergency obstetric care in rural areas remains the major challenge. Strengthening other supportive services, including family planning and delayed first birth, menstrual regulations, and education of women, are also important for achieving MDG 5.

Women and Health is a study by Patricia Smyke et.al. (1993) to understand the level of women's health as one of the major factors determining their ability to contribute individually and collectivity to a nation's development.

Women do in fact provide mist of the health care in the world. They need to be supported in that role so they can do an even better job, for their own sake and for the good of their families, communities and nations. PHC strategies recognize this. Many different factors affect women's health all of them interrelated. Which we talk about them separately an inter sect oral approach is almost always needed when it comes to action. Effective action on women's health may well involve action in the fields of agricultural, environment, education, commerce, justice, foreign affairs, human development and so or not to mention action to change basic attitudes towards women.

There is a tendency to look at a women's health at a specific moment in time, for example at the moment she becomes pregnant or becomes ill enough to go to a clinic. It is well to remember that her health status reflects the cumulative effect of all that she has experienced over a lifetime. Women have both general health needs the same as the rest of the population, and health needs that are specified to them as women. They need access to health care that enables them to satisfy all these needs.

'Assessing the MANOSHI Referral System: Addressing Delays in Seeking Emergency Obstetric Care in Dhaka's Slums' (*MANOSHI* Working Paper Series, ICDDR,B and BRAC, 2010) is a study carried out in twelve slum areas of Dhaka city, where BRAC has 238 delivery centers. The study targeted the women who had history of obstetric complications during pregnancy and child birth. The obstetric complications referred from delivery centers of MANOSHI (*Ma O Nobajatak Shishu*) working area were the study group, and cases referred from the community/home to the referral hospitals during October to December 2008 were

the comparison group. The majorities (74%) of the respondents were aged 20-35 years and women who were referred from home were more than two years older than the comparison group. The study examined the socio demographic status of respondents, reproductive and birth history, obstetric complications, the three delays in the referral system and factors associated with these delays, cost of delivery and outcomes of delays, and the role of MANOSHI referral system in reducing the three delays. The three delays in the study were defined as: 1st delay (time in decision-making) was the interval between recognition of the complication to starting for the facility to seek care; 2nd delay (time to arrive at the facility) was the interval between starting for the facility and reaching it (time needed for acquiring transport included) and 3rd delay (time in receiving treatment) was the interval between reaching the facility and the time the treatment was received.

More women referred from home experienced the first delay (73.3%) than women who had been referred from delivery centers (66.2%). The median times for making decisions among women referred from delivery centers for life-threatening and high-risk conditions were significantly shorter than that of those who were referred from home. The findings showed that of women who were referred from the community/home, the respondent's family members took a significantly longer time to make decisions in seeking care. In both groups, husbands were the prime decision-makers (48% and 51%).

More women who had the second and the third delays were referred from delivery centers, compared to women referred from home (65.3% vs. 19.1%; 58.7% vs 15.1%). The median times to reach the facility and receive treatment were almost same in both groups.

The study also find out the main causes of delay in decision-making were-Fear of medical intervention; Inability to judge the graveness of complications; Lack of money; Complications arising at midnight and traditional beliefs or conservativeness. It was observed that the husband and other decision-makers played an enormous role in making the decision to seek care.

Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination against Women is a work by Dr. Carmel Shalev for CEDAW. The ICPD recognized women's rights to reproductive and sexual health as being key to women's health. The basis for these rights can be found in various articles of the Convention on the Elimination of All Forms of Discrimination against Women. This paper examines the textual framework of women's rights to sexual and reproductive health as expressed in this and other international human rights documents. Rights to reproductive and sexual health include the right to life, liberty and the security of the person; the right to health care and information; and the right to non-discrimination in the allocation of resources to health services and in their availability and accessibility. Of central importance are the rights to autonomy and privacy in making sexual and reproductive decisions, as well as the rights to informed consent and confidentiality in relation to health services. The paper is illustrated by issues that reflect systemic violation of the above rights in varied forms, including maternal mortality, lack of procedures for legal abortion, inadequate allocation of resources for family planning, coercive population programs, spousal consent to sterilization, and occupational discrimination of pregnant women. Country examples are taken from States Parties' periodic reports under the Women's Convention.

Manoshi Midline Survey of Dhaka Slums (ICDDR,B & BRAC, 2009) is the second community based cross sectional survey of 3,048 (1,524 women having infants and 1,524 women with

children aged 1-4 years) women residing in 100 sample slums in Dhaka Metropolitan area (DMA). The midline survey 2009 collected data similar to the baseline survey 2007, on knowledge, perceptions and practices related to maternity care and newborn and child care of women having under-five child (ren) living in slums in the DMA. The overall objective of the 2009 midline survey was to estimate changes (improvements) in maternity, newborn and child care knowledge and practices. The survey shows that the slum women of 2009 were less migratory than their counterparts in 2007. One in every five women was permanent residents in the slums in 2009 compared to one in every fourteen women in 2007. The most common reason for migration in 2009 was income/employment whereas familial was the most important reason in 2007.

In survey area, Women's knowledge of the requirement for antenatal care (ANC) visits and TT vaccination were universal and near universal for iron supplementation in 2007 and 2009. However, less than half (42-47%) of the women knew that the required number of ANC visits was four or more. This value was a little higher (47%) in the program slums in 2009 than in 2007 (45%). Women's knowledge of the requirement of postnatal care (PNC) was lower (84% in the program slums and 83% in the comparison slums) in 2009 than in 2007 (94% in the program slums). On the other hand, 73% of women had knowledge about the requirement of Vitamin-A and 76% had knowledge about the need for Iron supplementation after delivery in the after delivery in the program slums in 2009. This level of knowledge was much higher in 2009 compared to 67% having knowledge on Vitamin A and 72% on Iron supplementation in the program slums in 2007. The institutional delivery accounted for half of the deliveries in program slums in 2009 compared to 24% in the comparison slums in 2009 and 15% in the program slums in 2007.The women's knowledge on newborn and neonate care went up in 2009 compared to 2007 while knowledge of cord care went down. ANC use went up in 2009 compared to 2007. Most ANC utilization occurred in BRAC Delivery huts and NGO health centers. While half of deliveries still took place at home, deliveries in health facilities accounted for the other half in 2009, up from 15% in 2007. PNC visits more than doubled in program slums in 2009 compared to 2007

The overall knowledge of women about major maternal complications during as well as within 42 days of delivery that required medical treatment was low. Knowledge of life-threatening pregnancy complications (except for lower abdominal pain and reduced fetal movement) was more frequent in the program slums in 2009 than in 2007 and the comparison slums in 2009.

"Sibling Influences on Adolescents' Attitudes toward Safe Sex Practices", (2004) is a journal paper written by Amanda Kolburn Kowal, and Lynn, Blinn-Pike. The study suggested that sibling discussions about safe sex, in conjunction with parental discussions, predicted better attitudes toward safe sexual practices for adolescents. Perceptions of sibling relationship quality were more closely associated with sibling discussions about safe sex than were older siblings' general attitudes toward safer sexual intercourse. Thus, sibling relationship quality may serve a protective function by facilitating more frequent sibling discussions about safe sex.

'Reproductive Health Behaviors' (2002) is a study of theses paper *by* Mohammad Mahbub Alam Talukder on slum dwelling couples of *Chittagong* city. From socio-economic and demographic view point, *Santinagar* slam is no exception from typical slums of big cities like Dhaka and *Chittagong*. It depicts similar magnitude of improvisation in settlements, over crowning and congestion, paucity of proper ventilation over dependents on the utilization of surface water (canal) for the purpose of bathing clearing of cooking utilities, (except drinking)

in all such matters from health perspective. The level of education attained by the slum couples under study is predominantly limited to primary and secondary schooling at best, in both male and female components. He mentioned in his study socio-economic and demographic characteristics, Education study, Emigrational, occupational studs and family income of slum dwellers. Dimensions of the Reproductive health; concept of pregnancy, cognition of conception, Rituals and restriction during menarche, Age at menarche, age at marriage, during of conjugal life, age at women at first child birth, Birth interval, total number of children, future FT method use, Decision making with about FP. Decision making process about pregnancy, food restriction during pregnancy etc.

'Strengthening Health Systems Capacity to Monitor and Evaluate Programs Targeted at Reducing Abortion-related Maternal Mortality' (2010), is a working paper of ICDDR,B. The paper mentioned that unsafe abortion persists as a leading cause of preventable maternal mortality and morbidity in Bangladesh. Improving women's ability to prevent unplanned pregnancy and to access safe care is critical to fulfilling Bangladesh's commitments to improve maternal health and to uphold women's rights. The Safe Menstrual Regulation Care (SMRC) model is designed to build the capacity of health systems to track and measure progress towards these ends. The SMRC model uses seven indicators and a set of signal functions designed to measure whether health facilities are providing all service elements most critical to reducing unsafe abortion and related injuries or death: contraception to prevent unwanted pregnancy, menstrual regulation (MR) and safe abortion for all legal indications, and treatment of abortion-related complications (abortion complications).

Abortion is legal in Bangladesh only to save a woman's life. Menstrual regulation-defined as evacuation of the uterus performed by a trained provider within 10 weeks of a missed period—is also sanctioned by the government. Menstrual regulation (MR) has been officially provided since 1979 by physicians and paramedics at all levels of the healthcare system through the Bangladesh MR program. The program has now been incorporated within a reproductive health and rights agenda, and currently provides services through a nationwide primary care level program.

A key assumption of the model is that if the package of SMRC services are broadly available, used by women and of sufficient quality, unsafe abortion and related mortality will decline. This mission aimed to assess the utility, feasibility and acceptability of implementing the SMRC tools in public sector, NGO, and private sector health facilities in *Jessore* district in Bangladesh.

'Women's Health and Human Rights: Monitoring the Implementation of CEDAW' (2007) is published by World Health Organization, Department of Reproductive Health and Research. This guide explains how human rights related to health are enshrined in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), governmental obligations to implement those rights and monitoring of those obligations by the CEDAW Committee. It concludes with suggestions for maximizing WHO's use of the CEDAW monitoring process. The book provides information on how WHO can assist countries in complying with their treaty obligations for women's rights, including the elimination of discrimination against women in the area of health care.

'Relationships of Exclusion and Cohesion with Health: The Case of Bangladesh' is a study conducted by Heidi Bart Johnston (2009) for ICDDR'B. The concept of social exclusion, applied widely in the European Union, has in recent years been gaining use in Bangladesh,

mostly by international development agencies. Does this discourse of deprivation, developed in the welfare states of northern Europe, have salience in its application to deprivation in countries like Bangladesh where, for example, 31% of the rural population lives in chronic poverty? The concept of social exclusion has three principal components: a dynamic and relational perspective which requires the identification of who or what causes exclusion; an explicit recognition of multiple dimensions of deprivation; and a longitudinal perspective, recognizing that individuals and groups are dynamic intra- and intergenerational. The Social Exclusion Knowledge Network of the World Health Organization Commission on Social Determinants of Health expanded the concept to include health status as a contributor to and an outcome of exclusion and to show that actors beyond the state or public sector can critically impact exclusionary processes. In the Bangladesh application, the relevance of the modified model was explored to find that while there are negative associations between social exclusion and health status, much stronger documentation is needed of the relationship. The modification of including multiple sectors, such as private enterprise and civil society, in addition to the state, as having potential to impact exclusionary processes is fundamental to the application of the social exclusion model in Bangladesh.

'Sexual Transmitted Disease's (1994), is a study to understand the recent decade's fatal diseases, AIDS and HIV found to be directly related to sexual transmissions which are becoming incredibly dangerous for human health. Such disorders are arising mostly from drug addition and unsafe sex practices. Women are also the victims of highly dangerous sexually transmitted diseases (STD) despite the fact male people are the carriers of such disorders.

This situation is exacerbated by the worldwide increase in incidence of sexually transmitted diseases and HIV infection and by the fact that women often talk access to the means to prevent pregnancy and to protect themselves against infection. With increasing awareness and concern about the role men play in the transmission of STDs/HIV and AIDS, marginalizing men in family planning and reproductive health services is not appropriate. Ignoring men's needs greatly increases their health risks, as well as those of their partners (Heise L.L 1994) women in Rural Bangladesh suffer from a broad array of reproductive health problems, which have an adverse impact on this health, their marital and familial relationships and their economic contributions. In Bangladesh, 25% of almost 3000 women's surveyed reported symptoms of a reproductive tract infection (RTI) and two thirds of these had clinical or laboratory evidence of infection. (H.H. Akther et. al. 1992).

The article "Social and Logistical Barriers to the Use of Reversible Contraception among Women in a Rural Indian Village" *(*HEALTH POPUL NUTR, ICDDR,B, 2008*)* **is** written by Mary Ann Kirkconnell Hall, Rob B. Stephenson, and Sanjay Juvekar. This paper explores beliefs of women regarding reversible contraception in a context where women are able to achieve their fertility goals using sterilization and periodic abstinence with abortion as a back-up method. Women in a small coastal village in western India were asked to explain their preference for female sterilization over modern reversible contraceptive methods. Women publicly denied contraceptive use but privately acknowledged limited use. They obtained contraceptive information from other village women and believed that modern reversible methods and vasectomy have high physical and social risks, and fertility goals could be achieved without their use. Women felt that reversible contraception is undesirable, socially unacceptable, and usually unnecessary, although the achievement of fertility goals is likely due to the use of female sterilization with abortion as a back-up method. Economic migration of village men may also play a role. Although women with high social capital can effectively disseminate correct knowledge, the impact on the uptake of reversible method is uncertain.

Bangladesh Maternal Health Service and Maternal Mortality Survey (1993) is a survey conducted by NIPORT (National Institute of Population Research and Training). The result of survey indicates that more than half of mothers in Bangladesh do not receive antenatal care. For births that occurred in the three years before the survey, only 48 percent of mothers received antenatal care during pregnancy. Those who do received care tend to received it from doctors (24 percent) or nurse, midwives, family welfare visitors, medical assistant, sub-assistant community medical officer (15 percent). About 5 percent of mothers receive antenatal care from health assistant or family welfare assistant. Less than 1 percent of pregnant mothers receive antenatal care from traditional birth attendants (Dai). The survey results show that there are sharp differences in antenatal care coverage among subgroups in Bangladesh. Antenatal care is much more common for births to younger women and those of lower birth order. The urban-rural differentials in the percentage of births for which the mother had at least one antenatal care visit are quite large. Sixty three percents of urban birth had received antenatal care from a medically trained person, compared with only 41 percent of rural births. The use of antenatal care is strongly associated with level of education and economic status. Mothers with some secondary education are about twice as likely as mothers with no education to received antenatal care and mothers in the wealthiest household are more than twice as likely to received antenatal care as mothers in the poorest household.

Transforming Health Systems: Gender and Rights in Reproductive Health is published by World Health Organization, Department of Reproductive Health and Research (2001). The result of a six-year testing and adaptation process involving strong collaboration with institutions in different parts of the world, this training manual provides a unique training curriculum designed to equip participants with the analytical tools and skills to integrate gender and rights into program and policy development in sexual and reproductive health. Gender and rights are woven throughout the curriculum which uses participatory methods and case-studies on many different aspects of sexual and reproductive health including contraception, pregnancy and childbirth, abortion, STIs and HIV, cervical cancer, violence against women and adolescents.

'Male Involvement in Reproductive Health Services in Bangladesh- A Review' is a study by Ali Ashraf, Thomas T Kane, Ahsan Shahriar, Barkat-e-Khuda (2006). A study on the use of modern contraceptives among urban men found that men have litter knowledge or understanding of female methods which prevents them from actively supporting their spouses in accepting, using or continuing to use the methods effectively. The males who were interviewed suggested using the media to motivate other males, to provide privacy at service centers and to provide individual counseling for males. Misconceptions about condoms and vasectomies contributed to their low use (common misconceptions included the fear of losing physical strength).

The study also revealed that communication between husbands and wives has had major implications on the degree of male participation in FP. The population council conducted a study of male clients visiting two male clinics in Dhaka for different services and found that 11 percents were STD clients and 28 percent were with other sexual health problems. The sociological evidence of a cross sectional study on the prevalence of STDs among Dhaka slum dwellers showed that current syphilis infection was prevalent in 11.5 percent of the men and 5.4 percent of the women. The prevalence rate of both gonorrhea and Chlamydia was less than one percent and the hepatitis B surface antigen was percent in 5.8 percent of the men and in 2.9 percent of the women's. Another community based study suggested that both men and women perceived sexual or reproductive health problem are fewer among men. It also indicated that in rural areas, men preferred first to consult unqualified practitioners for

reproductive health problems. According to one urban study, use patterns of health service among women and men differ women seem to be confined to private, for profit clinics, whereas men often just buy medicine at the pharmacy for some form of self-care. Urban men also prefer to visit pharmacies for their STD-related problems. The Laboratory Sciences Division (LSD) of ICDDR,B has been collaborating with the Bangladesh Women's Health Coalition (BWHC) clinic in Bangladesh to study the prevalence of RTIs/STDs and to plan for the sentinel surveillance of sex worker's, i.e. drug users (most male), transport workers, and STD patients. The LSD is also planning to carry out a baseline surveillance study of HIV/AIDS among various high risk groups of males and females. Several NGOs, such as Access to Voluntary safe contraception (AVSC), voluntary Health Services Society (VHSS), family planning Association of Bangladesh (FPAB), Paricharja, CARE, Nari Maitree, and Marie Stopes, have programmers of male involvement initiatives. These organizations have been working towards prevention and managing RTIs/STDs among males through offering services in the evening from specialized clinics run by male doctors; offering counseling with the use of both male and female counselors working with male and female clients in separate rooms; introducing separate cards for men to strengthen partner management; distributing reading materials on the prevention of STDs/AIDS for the purpose of rising awareness among the male and female college and university students; and developing a system of referral and linkage using local drug shops to refer customer to the clinic to RTIs/STDs. (ICCDDR'B special publication No. 94 and published 1999.

'Women, Reproductive Rights, and HIV/AIDS: Issues on Which Research and Interventions are Still needed' is a paper by Maria de Bruyn (2008). It is a ground theory based research output. This paper describes the main findings from the two exercises in relation to contraception for women living with HIV or AIDS, abortion-related care, legal adoption by HIV-positive parents, and reproductive rights. It concludes with a number of recommendations on topics to be incorporated into the international research agenda, policies, and programs in the field of HIV/AIDS.

'Conceptualizations of Sex among Young People in Malawi', 2010 (*African Journal of Reproductive Health* 11 (3), pp. 221-235). This paper explores how young people in Malawi conceptualize sex and sexual relations through an analysis of their personal narratives about these phenomena. Eleven focus group discussions were conducted with 114 youth aged 14-19 years. Participants were asked to describe behaviours, attitudes, and motivations to reduce unplanned pregnancies and the spread of HIV/AIDS, with appropriate probes to illuminate their sexual world-views. The various metaphors that emanated from the discussions suggest that young people in this study take a utilitarian approach to sex, and conceive it as a natural and routine activity of which pleasure and passion are essential components. Future research and prevention efforts (around sexuality education in particular) would do well to incorporate adolescents' language in programming as this can enhance understanding of the world of young people as well as the effectiveness of interventions addressing problems related to early sexual behaviour.

'Reproductive and Sexual Rights: Charting the Course of Transnational Women's NGOs', Geneva, June 2000, (Occasional Paper No. 8), is a paper which critically examines the role that transnational women's NGOs played in the 1990s in the creation and implementation of international agreements related to reproductive and sexual rights. Its focus throughout is twofold. First, it explores the multiple ways in which reproductive and sexual rights intersect with, and are embraced within, a wide range of health, human rights, social and gender justice and human development issues. Second, it uses this inquiry to rethink the complex political

dynamics in which transnational women's NGOs find themselves, as they man oeuvre within a globalizing yet deeply divided and grossly inequitable world.

The paper assesses recent successes and limitations of women's movements as agents of change in the international arena by focusing particularly on the work of organizations and coalitions active in the field of reproductive and sexual health and rights. Building on previous research, it analyses the "fault lines" between reproductive and sexual health/rights and their necessary economic, social and cultural enabling conditions.

The discussion here emphasizes the holistic perspective linking three components: *health*, *development* and *human rights*. It also shows how such thinking seriously challenges approaches that dichotomize rights and needs, individuals and communities, by investigating the necessary links, in both ethics and politics, between basic needs and fundamental human rights.

CHAPTER FOUR
Factor Influencing Women's Health

CHAPTER FOUR
Factor Influencing Women's Health

Women in developing countries are often in poor health and overburdened with work; they are tired, most are anemic, many suffer from malnutrition and parasitism and chronic ill health from lack of personal attaint iron and adequate health care especially during pregnancy and childbirth. According to International Committee on Population and Development Plan of Action (2009) (paragraph 7.3), reproductive health eludes many of the world's people because of such factors as: inadequate level of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behavior; ... discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives.

Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

In this chapter attempt has been made to find out the major factors which are influence peoples health. The socio-economic, demographic, cultural, political, environmental and other facts are influenced both male and female health. But some factors are particularly repercussion for women health on the basis of their socio-economic and biological status.

4.1 Biological Factors

Although human sexuality has come to many functions in addition to reproduction, its biological basis remains fundamental to the sexual experience. Sexual response involves psychological processing of information, which is influenced by learning, physiological responses and brain mechanisms which link the information processing to the physiological response. Although there is much that is not well understood about this complex sequence, it is understood that individuals vary considerably in their capacity for physical sexual response. This variability can be explained only in part by cultural factors. The role of early learning or genetic factors, or an interaction between the two, remains to be determined by further research.

Reproductive hormones are clearly important. However, their role is best understood and most predictable for men and much more complex for women. For example apart from the fact that women may experience a variety of reproduction related experiences the menstrual cycle, pregnancy, lactation, the menopause, and hormonal contraception all of which can influence their sexual lives, there does appear to be greater variability among women in the impact of reproductive hormones on their sexuality (Bancroft, 1987). In addition, variations in the onset of puberty and menstruation can represent special challenges for girls in some populations. The following table- 4.1 shows how the biological factors influence women's reproductive health.

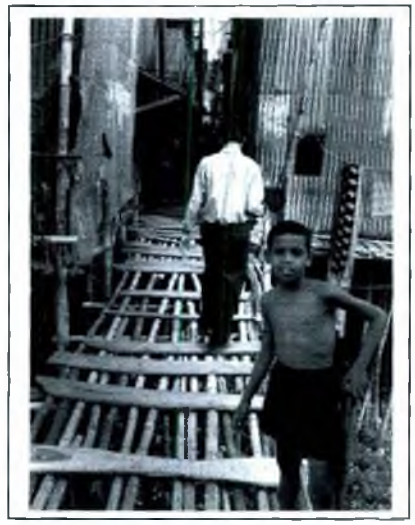
Table: 4.1 Biological Factors responsible for Women's Reproductive Health

Factors	No	%
Menstrual cycle	30	30
Onset of puberty and menstruation	25	25
Lactation and menopause	20	20
Hormonal situation	25	25
Total	**100**	**100**

Table 4.1 indicates that about 30% of the couple has mentioned menstrual cycle to be the major biological factor for women's reproductive health whereas 25% of Onset of puberty and menstruation 20% of Lactation and menopause and 25% of hormonal situation respectively.

4.2 Poverty Situation

More than one billion people, most of them women, live in extreme poverty. Women are more likely to be poor than men and to be among the poorest of the poor. There is a widening gap between the "better off poor" and the "extremely poor". The following photograph 1 shows the housing of an extremely poor family in the *shamoly* slum.



Photograph-1: Housing of an extremely poor family

Poverty of course affects the health of every one, not just woman. Especially very poor people who live at slum area have not enough food or the right kinds of food, no decent house, water supply and sanitation. Not being able to get health care when needed, it will operate with deadly efficiency to make the situation mere difficult for women. (Patricia Smyke, 2001) Because, the poor women spend more time and energy for cooking food or looking for food that they can afford to buy. Usually they are unskilled and uneducated, so they are obliged to accept whatever work or occupation they can get. Following tables-4.2 and 4.3 show the occupational status of the male and female respondents to understand their poverty situation.

Table:-4.2 Occupational Status of the Male Respondents

Occupation	No	%
Day Labor	42	42
Rickshaw Puller	21	21
Small Business	13	13
Service	24	24
Total	**100**	**100**

Table-4.2 shows that 42% of the male respondents earn their living by day laborer, 21 % by Rickshaw pulling, and 13% with small business and rest 24% is service holders. These figures tell again their illiteracy, lack of skill ness and empowerment.

Table:-4.3 Occupational Status of the Female Respondents

Type of Occupation	No	%
Purely house wife	65	65
Garments worker	30	30
Swing	02	2
Small Business	03	3
Total	**100**	**100**

Table-4.3 shows the occupational status of female member of respondents. The major portions 65% are purely house wife, 30% are garments workers, and a small portion are living by swing (2%) and small business (3 %). That means more than of majority female respondents are depend on their male partner. The following photograph-2 shows the nature of work that the slum women are engaged in both inside and outside their house.

Photograph-2: Nature of internal and external household activities of the slum women

The occupational status of the respondents, in turn, affects as well as determines their monthly income which, in the long run, put impact not only on their health but also their poverty situation. The following tables-4.4 and 4.5 show the monthly income of the male and female respondents.

Table:-4.4 Monthly Income of the Male Respondents

Income (in Tk.)	No	%
Bellow-2000	05	05
2001-3000	20	20
3001-4000	65	65
4001 & above	10	10
Total	**100**	**100**

In Table-4.4 (figure-1) the picture of the economic marginality of the slum dwelling people is confronted in any similar setting elsewhere. Given their background of high scale illiteracy as well as the lack of vocational skill, the monthly income tends to be seasonally variable and inadequate for bare survival. Only 5% male respondents have a monthly income of bellow taka 2000. The average income level (65%) is Tk.3000 to 4000 and 10% of the respondents' income is above 4000.

Table:-4.5 Monthly Income of the Female Respondents

Income (in Tk.)	No	%
Bellow-1000	67	67
1001-2000	30	30
200 and above	3	3
Total	**100**	**100**

In Table-4.5 (figure-2) the picture of the economic marginality of the slum dwelling female people is confronted in any similar setting elsewhere. Given their background of high scale illiteracy (55%) as well as Occupation Status (65% house wife); the monthly income tends bellow rather than male respondents. Only 3% female respondents have a monthly income of taka above 2000. The average income level (65%) is taka bellow 1000 and the rest 30% of the respondents those monthly income is from taka 1001-2000.

Though poverty has a direct and measurable impact on women's health, there is another condition, i.e. the status of women whose impact is equally important. It is a slippery concept to define especially in a cross cultural context. Perhaps it is better to define it by example, as the International Labor Organization (ILO) did. Women are half of the world's population, receive one tenth of the world's income, account for two-thirds of the world's working hours, and own only hundredth of the worlds properly.

Here the status means the position or rank in relation to others. It leads to conclusion about the right to participate on an equal basis, the right to share in decision-making, the right to do things that others do or die. Having no part in family planning decision and in the allocation of family resources are examples of status related factors that have a profound impact on women's health.

4.3 Demographic Factors

Demographic factors affect women's health in two ways. One is "macro" level impact that refers the whole society; and the other is "micro" level impact that indicates the individual or family. At the macro level the continuing population growth strains on the environment that makes our life more difficult, because the number of population is gradually increasing. But

there is no increase in food, water, sanitation, education and employment opportunities. So, the consequences of these are great on the poor women.
At the micro level, the decision about family size is made by each couple. And the opportunities what they have for the education, employment and others can be one of the major determinations of a woman's and her family's lifelong chances for good health.

4.4 Partner and Other Family Members

A number of family factors are known to be associated with reproductive sexual behavior and the risk of pregnancy. Specially, adolescents living with a single parent are more likely to have had sexual intercourse than those living with both biological parents (Miller, 1998). Having older siblings may also influence the risk of adolescent pregnancy, particularly if the older siblings have had sexual intercourse, and if an older sister has experienced an adolescent pregnancy or birth (East, 1996; Widmer, 1997). For girls, the experience of sexual abuse in the family as a child or adolescent is linked to increased risk of adolescent pregnancy (Browning, 1997; Roosa, 1997; Miller, 1998). In addition, adolescents whose parents have higher education and income are more likely both to postpone sexual intercourse and to use contraception if they do engage in sexual intercourse (Miller, 1998).

The quality of the husband-wife relationship is also significant. Close, warm husband-wife relationships are associated with both postponement of sexual intercourse and more consistent contraceptive use by sexually active partner (Jaccard, 1996; Resnick, 1997).

4.5 Community

Community can be defined in several ways: through its geographic boundaries; through the predominant racial or ethnic makeup of its members; or through the shared values and practices of its members. Most persons, particularly males are part of several communities, including neighborhood, school or work, religious affiliation, social groups, or sports teams. Whatever the definition, community influence on the sexual health of those who comprise it is considerable, as is its role in determining what responsible or right sexual behavior is, how it is practiced and how it is enforced.

The measurable physical characteristics of neighborhoods and communities, such as economic conditions, racial and ethnic composition, residential stability, level of social disorganization and service availability have demonstrated associations with the sexual behavior of their residents-initiation of sexual activity, contraceptive use, out-of-wedlock childbearing and risk of STD infection (Billy and Moore, 1992; Grady, 1993; Billy et al, 1994; Grady et al,). An understanding of these characteristics and their impact on individual is important in planning and developing services to improve the reproductive health and promote the responsible sexual rights to their own life.

4.6 Culture

A shared culture based either on heritage or on beliefs and practices, is another form of community. Each of these communities possesses norms and values about sexuality and these norms and values can influence the sexual health and sexual behavior of community members. For example, strong prohibitions against sex outside of marriage can have protective effects with respect to STD/HIV infection and adolescent pregnancy (Comas-Diaz, 1987; Kulig, 1994; Sudarkasa, 1997; Amaro, 2001).

When a community-defined by its culture--also has minority status, its members are potential objects of economic or social bias which can have a negative impact on sexual health. Economic inequities, in the form of reduced educational and employment opportunities, and the poverty that often results, has obvious implications for accessing and receiving necessary health education and care.

4.7 Political Factors

For a long time there was no recognition to women's role in development activities. Especially their household works including food producing and child minders as there are not for paid. But Now-a-days, policy makers understood that paid or unpaid work of women has a great contribution to development. Different policies have an impact on women's status and their health directly. There are many policies existing in this content such as these of Primary Health Care (PFC) which illustrates:

- The insistence on making health care accessible to all:
- The Stress on intersect oral approach.
- The Emphasis on prevention.
- The place given to health information and education.
- The community participation and responsibility
- The ideal that people can take action to improve their health.

In addition, PHC recognizes the contribution that women have traditionally made to the health of their families and communities and calla for measures to support them in this role (Patricia Smyke, 2003).

4.8 Environmental Factors

Environmental factors have a direct impact on women's health. *Patricia Smyke* (2001) identified that, if PHC is carried out as intended, women's involvement in the process can lead them to new awareness of their own health needs and give them new confidence in their own abilities. Photograph-3 shows the reproductive health facility in *Shamoly* slum

Photograph-3: Reproductive Health Facility in *Shaymoly* Slum

Another policy matter with serious implications for women relates to the availability of modern health technology. There are dramatic illustrations in the field of reproductive health. In the poorer countries women die premature deaths because of a lack of equipment and facilities to handle obstetric emergencies. Besides this there are many policy matters related to family planning that make critical differences for women's health.

In Both urban and rural area economically poor women do not get available firewood facilities that indirectly impacts on women's health. Because of the scarcity of firewood they cannot cook food properly and so often is not possible to boil drinking water. At this result women face more problems of water related diseases. Patricia Smyke (2003) showed that community health. Sickness and disease in the developing world can be attributed to unsafe water and inadequate sanitation. Following photography-4 shows the environmental condition of the premises of Shaymoly Slum.

Photograph-4: Swimming in polluted water showing the environmental condition of the Slum

Because women are usually doing their work water related like as fetching water, washing clothes, working in irrigated fields etc. Besides this many poor women who work in the factories and industrial establishments may be exposed to harmful chemicals or radiation, with grave health risks for themselves and their unborn children. In developing countries, as we have seen, good nutrition or malnutrition is the pivotal factor in many of the circular relationships among women, health and development. In many rural communities women do the major share of the work to produce the family's food, as well as carrying the water and fuel needed to prepare it.

4.9 Health Care Professionals and Available Reproductive Health Services

Physicians, nurses, pharmacists and other health care professionals, often the first point of contact for individuals with sexual health concerns or problems, can have great influence on the sexual health and behavior of their patients. Yet, both couples frequently perceive that health care providers are uncomfortable when discussing sexuality and often lack adequate communication skills on this topic (Croft and Asmussen, 1993). Traditional typically do not receive adequate training in sexual aspects of health and disease and in taking sexual histories. Even then in the study area some health care facilities are available both from the govt. and non govt. organization and the health care professionals do some checkup, particularly of pregnant women.

In Bangladesh, contraceptive and reproductive health services are provided to women and men by a wide range of health care professionals. These services are offered in a variety of settings-private practice offices, NGO clinics, SHOUJAR HASHI Clinics, publicly funded family planning clinics, private clinics, military clinics, Union based health centers, and private hospitals. Often, contraceptive services are integrated with other basic preventive health services such as pelvic examinations and pap tests, and screening for sexually transmitted infections. In addition to medical care, counseling or education related to sexual and reproductive family health may be provided.

Barriers to obtaining these services can exist if providers are not conveniently located, are not available when needed, do not provide (or are thought not to provide) confidential, respectful, culturally sensitive care, or are not affordable (Forrest and Frost, 1996). Nationally subsidized family planning services have been an important factor in helping many persons overcome these barriers and control the birth rate. In addition some traditional hearing practices also exist in the slum areas where many of the families have interest and beliefs on these practitioners.

In above discussions it is clear that Women's health status is affected by complex biological, social and cultural factors which are interrelated and can only be addressed in a comprehensive manner. Reproductive health is determined not only by the quality and availability of health care, but also by a mixture of socio-economic development levels, lifestyles and women's position in society. Above discussions exposed the second objective of the study and analyzed the factors which influence women's health behavior in different ways. Generally, we see poverty is a leading independent cause and other causes are depending on it directly or indirectly. But when the question of reproductive rights it's depend on not only individual concern but also some socio-economic and environmental factors, especially partner, family members and community manners generate barrier towards established women reproductive rights. The polity of Bangladesh recognized the reproductive rights of women by both legal and international conventions/treaties, but the men lead society of Bangladesh did not allowed women to take a decision of their reproductive issue, even the men could not recognized it (reproductive health) is an issue of women.

CHEPTER FIVE
Findings and Analysis

CHAPTER FIVE
Findings and Analysis

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violenc.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. However, the findings of the study and its analysis is given in the following discussions and data presentation.

Table-5.1 Age Distribution of the Female Respondents

Age (in year)	No	%
19 and bellow	20	20
20-24	30	30
25-29	29	29
30 and above	21	21
Total	**100**	**100**

The age distribution of the male and female members of different households is mentioned in the table-5.1 and table-5.2 showing that in the *Shamoly* Slum among female 20% belonged to the age grade of 19 years or below, 30% in the 20-24, 29% in 25-29 and 21% in the higher age grade of 30 and above.

Table-5.2 Age Distribution of the Male Respondents

Age (in year)	No	%
20 and bellow	08	08
21-30	48	48
31-40	19	19
41 and above	25	25
Total	**100**	**100**

On the other hand among male member 8% are aged 20 year or below and the group aged between 31-40 years constitute 19%, 41 years above 25% and major portion is 48% aged between 21-30 years. It is noted that this major group is newly married group and more active in reproductive activities.

Table-5.3 Educational Status of the Female Respondents

Status	No	%
Illiterate	55	55
Primary	43	43
Secondary (vi-ix)	12	12
Total	**100**	**100**

The educational level of the reaches slum area under study of female respondents is predominantly illiterate and primary school at best. These are the presented in table-5.3. The major portion (55%) has not been enrolled in even primary level education and 43% got primary level education. Only a marginal portion (12%) is crossed to the secondary level.

Table-5.4 Educational Status of the Male Respondents

Education	No	%
Illiterate	43	43
Primary	31	31
Secondary (vi-ix)	24	24
S.S.C	02	02
Total	**100**	**100**

The educational level of the reaches slum area under study of male respondents is predominantly limited to primary and secondary school at best. These are the presented in table-5.4. The major portion (43%) has not been enrolled in even primary level education, shows 31% of male got primary and 12 % entranced to secondary level education. Only a marginal portion (2%) is crossed to the SSC level.

Table-5.5 Past Residence Location

Status	No	%
Another Slum	20	20
Own Village	67	67
Other Town	04	04
By Born	09	09
Total	**100**	**100**

Table-5.5 (figure-3) provide evidence to the observation made bellow. It seems that 67% of the families have migrated from their own village. Other families (20%) have shifted here from another slum and share the same background. The remaining families are born in other places. The common causes of exodus of rural people to urban places are river erosion, landlessness, natural calamities, and lack of opportunity for a source of income.

Table:-5.6 Distribution of the Male Respondents According to District

Name of the District	No	%
Comilla	34	34
Brahmanbaria	32	32
Noakhali	12	12
Netrakona	04	04
Barishal	14	14
Mymensing	04	04
Total	**100**	**100**

The place of origin of the slum dwellers are shows in the table-5.6 (figure-4). About one third of the male respondents have migrated from Comilla and another one third from Brahmanbaria. 12% came from Noakhali, and rest 4% are accordingly from Netrakona, Barishal and Mymensing.

Table-5.7 Reasons for Slum Dwelling

Reasons	No	%
There was no scope of work in village	55	55
For better Life	12	12
No wealth in village	08	08
River erosion	06	06
By birth	19	19
Total	**100**	**100**

Table-5.7 (figure-5) shows the reasons for migration where a number of factors were reported which is landlessness 08%, causes for river erosion 06% and lack of employment opportunities in village 55%.

Table-5.8 Type of Dwelling House

Type of Houses	No	%
Katcha	55	55
Semi-Pacca	39	39
Pacca	06	06
Total	**100**	**100**

The life style of their survey area is reflecting in the table-5.8 and table-5.9. In table 5.8, most of the people (55%) of this slum are living in *katcha* house. About 39% are living in *semi pacca* and only 6% brick built house.

Table-5.9 House Rent

Taka	No	%
Bellow-500	45	45
501-800	10	10
8001-1200	42	42
Own house	03	3
Total	**100**	**100**

Table-5.9 examines the rental cost involved in slum housing. 45% houses are rented on taka bellow 500 basically this are *Katcha* house, 10% house are rented on taka 501 to 800 this are new made *Katcha* house, while a significant number (42%) can afford to spend an amount of 800-1200 for dwelling, this houses are *semi pacca* and only 3% live in their own brick built house.

Table-5.10 Nature of Latrine

Nature of Latrine	No	%
Open Space	55	55
Pit	35	35
Safety Tanks	10	10
Total	**100**	**100**

Table-5.10 shows the natural of latrine usually the slum dwellers under study, most of the houses are predominantly dependent on the use of unsanitary latrines where 55% use space and 35% pit, which are by normal health standard. Only a few numbers of families 10% are found to have access to quasi-sanitary latrines.

Table-5.11 Age at Menarche of Women

Age (in year)	No	%
11	03	03
12	19	19
13	24	24
14	41	41
15	11	11
16	02	02
Total	**100**	**100**

Table-5.11 (figure-6) reveals that the age at which menarche occurs depends on varying factors like climate, environment, dietary habits, and to some extent the biological predispositions. The present study hints that the age at which menarche occurred varied between 11 years age (3%) to the maximum age of 15 years (11%). Nonetheless, 41% of the females under study experienced menarche at the age of 14, next following by those aged 13, (24%) and 12 (19%).

Table-5.12 Women's Age at First Marriage

Age (in year)	No	%
Bellow-14	12	12
15-17	51	51
18-20	26	26
21 and above	11	11
Total	**100**	**100**

Table-5.12 (figure-7) shows the women's age at first marriage. In study of slum area most of the women are (51%) marriage at the age range of 15-17. The average 26% of the women in the slum are marriage in the year 18-20. In this study area 12% marriage took place at childhood and only 11% are in the year 21 and above.

Table-5.13 Age of the Respondent when gave Birth to Her First Child

Age (in year)	No	%
15 -17	60	60
18 - 20	31	31
21 -23	09	09
Total	**100**	**100**

Table-5.13 shows a woman the birth to her first child- 60% of the female respondents have gave birth to their first child during the age 15-17, 31% and 09% respectively have given birth to their first child in the year 18-20 and 21-23 respectively.

Table- 5.14 Age of the Last Child

Age (in days)	No	%
0-45	10	10
46-90	11	11
91-135	39	39
136-180	40	40
Total	**100**	**100**

Table-5.14 shows age of the last child of a woman in study area, 10% of last child age is 45 days and 39% of last child age is 91-135 days. The highest 40% of the last child's age was 136 to 183 days.

Table- 5.15 Birth Spacing between Last Two Child

Age (in year)	No	%
Bellow 2	15	15
2-3	38	38
4	23	23
N/ A	24	24
Total	**100**	**100**

Poverty, illiteracy, early marriage and lack of health concuss are more effective for the spacing between last two child. Table-5.15 shows 15% of the female respondent's birth spacing between last two children is bellow 2 years. 38% with 2-3 years spacing between last two children. 23% are for 4 years and the rests 24% have mentioned nothing.

Table- 5.16 Total Number of Children

Number	No	%
1-2	55	55
3-4	28	28
5-6	17	17
Total	**100**	**100**

The total number of children in family is noted in the table-5.16. 55% of the family have 1 or 2, 28% have 3 or 4 and the rest 17% of the family have the total 5-6 children respectively.

Table-5.17 Family Planning Method status among the Respondents

Status	No	%
Past	26	26
Present	25	25
Did not received	49	49
Total	**100**	**100**

Table-5.17 shows the status of family method among the respondents. In past both male and female respondents (26%) had received family planning method but at present only 25% have taken this planning due to lack of education and awareness. 49% didn't take any family planning method. They think that child is a god gifted asset, why we are taking family planning.

Table-5.18 Current use of Contraception among the Respondents

Status	No	%
User of FP	25	25
Non user of FP	75	75
Total	**100**	**100**

Table-5.18 shows that among the family of the slum 75% of the respondents didn't used the contraception. They even did not want to know why to use this method. It happens not only due to lack of knowledge, also some male sexual fantasies are manipulated them for not taking any family planning plan. But only 25% of the respondents use this method.

Table-5.19 Distribution of contraceptive users method used

Methods	No	%
Pill	05	25
Condom	04	20
Inject able	07	35
IUD	01	05
Norplant	01	05
Tubectomy	01	05
Kobirazi (traditional), No method used	01	05
Total	**20**	**100**

Table-5.19 (figure-8) limited couples have adopted family planning (FP) method; the use of inject able method is restricted to 7 couples (35%), the use of pill to 5 adopters (25%), and Condom to 4 families (20%) and only 1 couple (5%) is used Norplant method. It shows that males are not interested to take any FP method; they (male) influenced their female partner to use any FP method. These data indicate the lower response of the proportion of interviewed families to the intensified program of population control program in the slum sub-culture.

Table-5.20 Reasons for not using Contraceptive Method

Reasons	No	%
Physical discomfort	20	23.51
To have baby	10	11.76
Husband opposed	20	23.55
Postpartum amenorrhea	25	29.42
Breast feeding, No contract	10	11.76
Total	**85**	**100**

The family respondents cited the following causes for non-adoption of contraception in table-5.20 (figure-9) 24% of the mothers are not using FP methods deliberately in order to have a baby, postpartum amenorrhea is 30%, opposition of husband is 24%, physical discomforts associated with the use of contraception is 24% and breastfeeding is about 12%.

Table-5.21 Future Status of FP Method

Status	No	%
Future	20	33.33
Yet not decided	20	33.33
No intention	20	33.34
Total	**60**	**100**

The data in table-5.21 points out that more than one third of the female respondents (33.33%) are not at all interested to be user of FP in future and desired to be reproductively active in future years. But 33.33% of them expressed their intent to be users of FP in the future and another 33.33% of them are yet undecided about their course of action in this regard.

Table-5.22 Future use of Contraception

Methods	No	%
Pill	25	41.67
Inject able	20	33.33
IUD	05	08.33
Tubectomy	07	11.67
Kobiraji	03	05.00
Anemia	**60**	**100**

Among the interviewed females their knowledge of family planning methods is very high, as indicate in table-5.22. The non user respondents could mention the name of methods such as pill; inject able method, IUD and tubectomy. The respondents categorically expressed their opinion about their choice of preferred method in later period which include pill is about 42%, inject able method is 33 %, tubectomy is 11.67% and IUD is 8.33%.

Table-5.23 Discussion of Family Planning Methods with Husband

Status	No	%
Yes	82	82
No	18	18
Total	**100**	**100**

These are indicating of sharing views on contraception use with their husbands. Table-5.23 shows that 82% of the total respondents involve in exchanging views with their husbands with regard to the use of contraception methods. This suggests the nature of mutual decision making among the partners in fertility regulation. Most of the respondent said that the ultimate final decision about contraception method was taken by their husband.

Table-5.24 Whether the decision of pregnancy taken jointly by the couple

Response	No	%
yes	70	70
No	30	30
Total	**100**	**100**

Table-5.24 shows that 70% of the survey couples did not share the decision about planning pregnancy before it occurs. Only 30% are concerned about sharing the decision about pregnancy. It reflects that both husband and wife felt the necessity about discussion among themselves whether they want a baby or not, There is an increase in realization for joint decision about pregnancy which indicates a good husband-wife communication development in the study area.

Table-5.25 Additional Food during Pregnancy

Status	No	%
Yes	35	35
No	65	65
Total	**100**	**100**

In the state of pregnancy requires additional intake of food than what is consumed in normal condition. It is necessary for proper development of the baby in the womb needs to be nourished from mother's nutritional intake. Table-5.25 reveals that the majority of the pregnant women depended on normal foods during pregnancy. Around 65% pregnant mother believed that there is no need to intake protein-rich food during pregnancy. However, the emphasis is given on the casual consumption of vegetables, seasonal fruits and eggs by the respondents. Their socio-economic and family structures are not allowing them to take extra nutritional food, even they want. Little number of respondents argues that during pregnancy they have taken extra food, but other members of their husband family through reddish comments. This time they suffered psychologically. The respondent added that about half of the newborn babies are identified as low weight children in their slum. This occurs primarily as a result of mothers' proper nutritional state during their pregnancy

Table-5.26 Pattern of Utilization of Adequate Rest during Pregnancy

Pattern	No	%
After middy meal	26	26
Whenever felt discomfort	25	25
whenever felt fatigue	49	49
Total	**100**	**100**

Table-5.26 shows that in survey area 26% of the pregnant women took rest after mid-day meal, 25% hold that the resting hour when they felt discomfort and 49% of pregnant woman rest whenever they felt fatigue and which forced them to leave bed little later than their normal habit. The behavioral pattern regarding restriction of movements during pregnancy reflects their own explanation based on perceptions, belief system of human reproduction and relates it with body mechanism to nature.

Table-5.27 Sharing the Household activities by the Husband at Wife's pregnancy

Response	No.	%
Yes	11	11
No	89	89
Total	**100**	**100**

Table-5.27 shows that 89% husbands did not share the burden of household work during this critical stage of their wives. The study revealed that female respondents are aware of their situation and take measures according to their ability than male. Majority of female respondents said that their male partner feel uncomfortable to help them in household work, particularly after new marriage.

Table-5.28 Pattern of Ritual Performed during Pregnancy Period

Rituals	No.	%
Stasher	85	85
Milad mahfil	11	11
Musical Program	04	04
Total	**100**	**100**

Table-5.28 indicates that about 85% of the females under study performed this ritual at the 6th month of the pregnancy. Apart from this, about 11% females arranged *milad mahfil* for safety of the pregnant women during child delivery.

Table-5.29 Complications Faced during Pregnancy

Response	No.	%
Yes	29	29
No	71	71
Total	**100**	**100**

Table-5.29 shows that the study area 71% of the female did not face any complication during pregnancy period but only 29% women faced a little or major complication when they were pregnant. Pregnancy and childbirth-related complications constitute the leading causes of maternal morbidity and mortality in slum of Bangladesh. Findings obtained from FGD indicate that women have limited knowledge of life-threatening complications of pregnancy. In FGD few female respondent argue that some time they felt some complication during pregnancy period but their male partner and other family members could not recognized its as a problem, also they suffer serially.

Table5.30 Types of Complications Faced during Pregnancy

Complications	No.	%
Bleeding during pregnancy	3	10
Oedema	10	34
Severe Vomiting	9	31
Convulsion	2	7
Leaking membrane before delivery	2	7
Anemia	3	10

Table-5.30 (figure-10) shows that following symptoms appear to be important in the study area: bleeding during pregnancy, oedema, leaking membrane before delivery, convulsion, severe vomiting and anemia. During pregnancy about 10% females have faced bleeding, about 34% faced oedema, 31% faced severe vomiting and 10% female have suffered anemia.

Table-5.31 Antenatal Care during Pregnancy

Status	No.	%
Sought ANC	49	49
No. ANC	51	51
Total	**100**	**100**

Table-5.31 show that the more than half of the mothers (51%) did not receive any antenatal care (ANC) and only 49% mothers received antenatal care during pregnancy period. Findings

obtained from field indicate that those women's who are not received ANC, but they take some tips from Allopathic Quake, *Kobiraz* or Religious Cleric.

Table-5.32 Pregnant Mother who took 1st Antenatal Check-up

Stage	No.	%
1st three months (1st Semester)	20	20
4-6 months (2nd Semester)	42	42
7-10 Months (3rd Semester)	38	38
Total	**100**	**100**

Table- 5.32 shows that in the study area only 20% of the pregnant women took antenatal check up in the first semester of their pregnancies, while about 42% received ANC check ups in the second semester, and most alarmingly 36% of the women had same at the last semester just before child delivery.

Table5.33 Time of Antenatal Check-up during Pregnancy Period

Time	No	%
One time	42	42
Two times	34	34
Three times	18	18
Four times and above	6	12
Total	**100**	**100**

In table-5.33 indicates that 42% of the mothers received only one ANC visit and 34% had two ANC checkups. Only little, more than one third of the pregnant women (18%) complete three visits. The portion of those who had 4 ANC visits is restricted to only 6%. Most of the respondents said that basically due to economic status they can not go ANC checkup more times. And some times they could not motivate to go ANC because of negative manner of other family members.

Table-5.34 Last Antenatal check-up Taken before Delivery

Week	No	%
Within one week	16	32.00
Within two weeks	03	06.00
within four weeks	17	34.00
Five weeks and above	14	28.00
Total	**50**	**100**

Table-5.34 shows the dominant pattern prevalent among the surveyed families is reflected in the avoidance of getting crucial ANC test in the last 3 weeks before the expected delivery. About 34% of such women at advanced level obtained the last ANC check up six weeks back prior to their deliveries. Those who completed ANC test 3 weeks ago account for 28% of the women. The proportion of the women who obtained AN Check up within 2 weeks time is very low approaching 6% and visiting one week ago only 32%.

Table-5.35 Reasons for Vaccination during Pregnancy

Reasons	No	%
vaccine protect women against pregnancy	46	46
Child may die in the womb if vaccine is not given to pregnant mother	16	16
Women do not become ill if vaccine taken	23	23
vaccine is given for a healthy baby	6	6
No idea	9	9

In table-5.35 a close examination of the perception of the women subjects depicted that the lay notions of the women about the benefits of immunization are: vaccine protects women against tetanus which is 46% vaccine minimizes the risk of illness among women is portion 23% and Child remains safe in the womb if mother is vaccinated is 16%.

Table5.36 Reasons for not taking Vaccine during Pregnancy

Reasons	No	%
Due to fear vaccine was not taken	06	27.27
Vaccine harms the baby in the womb	04	18.18
Vaccine was not available	05	22.73
Vaccine brings about physical weakness	07	31.82

Table-5.36 hows that 6 women did not received immunization. They did not take vaccine due to the fear of being hurt as a result of injection (27.27%), the suspicion that vaccine harms the baby in the womb is 18.18%, vaccine bring about physical weakness of portion 22.73% and non availability of opportunity for vaccine in the locality is as 31.82%.

Table-5.37 Husband Accompanied Wife for ANC Check-up

Response	No	%
Accompanied wife	14	14
Husband not accompanying	86	86
Total	**100**	**100**

From the respective data displayed in the table-5.37 it is observed that in case of 86% of visits for ANC check-up, the husband did not accompany their wives to the health centre or clinic.

Table-5.38 Reasons for not Accompanying Wife during ANC Visit to Health Center

Response	No	%
Wife can visit alone	32	37
Husband does not know much about ANC	17	20
Husband remain busy with other activities	28	33
It is embarrassing to go with wife at pregnant state	9	10

The table-5.38 shows that Various reasons were given by the male respondents for failing to accompany their wives in such important matter, such as (a) males know little about ANC is 20%, (b) Husbands have other works to do is 33% and (c) such matter is embarrassing for a man to face is 10%.

Table-5.39 Decision making pattern: Place of stay during 1st child birth

Place	No	%
Husband Residence	39	39
Women's father residence	61	61
Total	**100**	**100**

A characteristic behavior pattern for choosing father's home as the place of first child delivery springs from several considerations. In depth discussion yielded some clues to the fact that the delivery the presence of close kin's particularly of her mother reassure the confidence of the pregnant woman. A decision in which husband's view predominates. Table-5.38 amply brings forth that 61% of the childbirth take place at husband's residence and 39% in wife's paternal house. Findings show that husband plays the decisive role in the selection of place where the child delivery took place. In the study area, almost all the deliveries took place at homes attended by the traditional birth attendants and while only few deliveries were conducted by paramedics, nurses or doctors at the governmental healthcare centers or local BRAC delivery center.

Table-5.40 Types of Complications faced after Child Birth

Types of complications	No.	%
Fever more than 3 days	05	23.81
Convulsion	05	23.81
severe bleeding	07	33.33
Smelly vaginal discharge	04	19.05
Total		**100**

The nature of complications confronted by mother after childbirth is as identical as observed elsewhere shown in the table-5.40. Out of 100 female respondents 21% faces complications after childbirth. They include continual fever for three days about 23.81%, convulsion about 23.81%, severe bleeding about 33.33%, and smelly vaginal discharge about 19.05%. It is essential that the mothers need to take postpartum rest following childbirth for a considerable period of time.

Table-5.41 Responsiveness about exclusive Breast Feeding Status

Status	No.	%
Yes	71	71
No	29	29
Total	**100**	**100**

As per the data presented in table-5.41 a positive sign is that about two third women (71%) tend to practice full breastfeeding. Normally, from scientific standard, breastfeeding should continue for at least 3 years. Contrarily, the slum mothers tend to being feeding supplementary food to their children side by side with breastfeeding is 29%. It has been observed that the knowledge on the high nutritional value of colostrums milk among the mothers is somewhat absent. There is a wide misconception that such milk is not suitable being impure in its substance, which is quite wrong. It has protective resistant power to enable the newborn child in gaining biological immunity against many infectious diseases.

Table-5.42 Whether Father Attended the Sick Child

Status	No	%
Attended	09	26.47
Not attended	25	73.53
Total	**34**	**100**

The attitude of the male household heads in the utilization of available health care facilities in the community particularly for their wives and infants seem to be yet a matter of great concern. As table-5.42 unfolds, about 73.53% of the male household heads failed to turn up with their sick children to the health centers. Most often, it is the mother who performs the responsibility to look after their sick offspring as well as their treatment.

Table-5.43 Knowledge on HIV/AIDS

Status	Male		Female	
	No	%	No	%
Yes	73	73	62	62
No	27	27	38	38
Total	**100**	**100**	**100**	**100**

An inquiry from the respondents demonstrated that 73% of the male and 62% of the female respondents possess no knowledge of either AIDS or HIV shown in the table-5.43 (figure-11). This calls for urgent health education about the danger posed by unregulated, unsafe, and promiscuous sexual life among the slum dwellers. This is more important, it is the slums that may be quick recipient of such sexual transmitted diseases in future.

The socio-economic positions and male dominant society structure of urban slum in Bangladesh could not give access to women in decision making process of reproductive issues. In the study area we see that the majority of the women's occupations are housewife and they are also illiterate and migrate from outside Dhaka. For this reason they are completely depends on their male family partner. In case of their economic condition the female member can not purchase any health related products (like-medicine, pill, condom, etc.) or services independently. Even they can not go health centre without their male partner's pre-appraisal. So, socio-economic and family manner some times make barrier to established women reproductive rights in individual family life.

On the other hand we see in the study area, the female who got access in decision making process they are occupied in service and got some primary or some secondary education. So women empowerment is also play a crucial role in establishment of women reproductive rights and sound health. In FGD discussions, most of the couples said in their first conceive they can not discuss or plan before it occurs. They believe that it's a natural process and male partner decide he want a baby or not. We analysed the demographic data of this segment and we find that their age group is late twenty; also they are totally illiterate and housewife. But a small portion of respondents said they discussed the issue and take a plan before conceive. Those ages rage is late thirty and they having more than one child and or also they have got little bit primary or some secondary educations. Its seem to say that if increased the women education, economic status and empowerment, the reproductive rights and sound health should be established smoothly. It noted that poor Sexual Reproductive Health (SRH) is a source of enormous suffering for slum people of the Dhaka city as well as millions of the world's poorest people. It accounts for a high proportion of the global burden of ill health,

particularly for reproductive age women both in urban ad rural setting. Yet it is a largely invisible burden in many countries. In Bangladesh, despite two decades of sustained effort, progress on improving SRH has remained slow and SRH rights are often not understood or remain unrealised in practice. As well as being a denia of human rights, denial of SRH and rights affects physical security, bodily integrity, health, education, obility, and economic status.

CHAPTER-SIX
Conclusion and Recommendations

CHAPTER-SIX
Conclusion and Recommendations

The reproductive rights of women are advanced in the context of the right to freedom from discrimination and the social and economic status of women. Control over reproduction is a basic need and a basic right for all women. Linked as it is to women's health and social status, as well as the powerful social structures of religion, state control and administrative inertia, and private profit, it is from the perspective of poor women that this right can best be understood and affirmed. Women know that childbearing is a social, not a purely personal, phenomenon; nor do we deny that world population trends are likely to exert considerable pressure on resources and institutions by the end of this century. But our bodies have become a pawn in the struggles among states, religions, male heads of households, and private corporations. Programs that do not take the interests of women into account are unlikely to succeed

Attempts have been made to analyse the socioeconomic conditions that affect the realisation of a woman's reproductive rights. The term reproductive justice has been used to describe these broader social and economic issues. Proponents of reproductive justice argue that while the right to legalized abortion and contraception applies to everyone, these choices are only meaningful to those with resources, and that there is a growing gap between access and affordability.

A human rights approach is a powerful tool in the fight to save women from Alyne's fate: it holds governments accountable, places women's health and well-being at the center of efforts to reduce maternal deaths, and empowers women to defend their right to maternal health. For this reason, leading human rights and public health advocates from around the world launched the International Initiative on Maternal Mortality and Human Rights in 2007. This initiative, the first of its kind, urges policymakers, donors, and activists to tackle maternal health as a human rights imperative.

Women's disproportionate poverty, low social status, and reproductive role expose them to high health risks, resulting in needless and largely preventable suffering and deaths. Many of the women and girls who die each year during pregnancy and childbirth could have been saved by relatively low-cost improvements in reproductive healthcare; yet high levels of maternal mortality persist. The benefits of eliminating the harmful and painful practice of female genital mutilation are easily demonstrated, yet it persists for cultural and traditional reasons. And a large proportion of abortions, some resulting in death and injury, would be avoided if women and men had access to safe, affordable and effective means of contraception.

Women's health status is affected by complex biological, social and cultural factors which are interrelated and can only be addressed in a comprehensive manner. Reproductive health is determined not only by the quality and availability of health care, but also by socio-economic development levels, lifestyles and women's position in society. In fact, the International Federation of Gynecology and Obstetrics asserts that improvements in women's health require state action to correct injustices to women. In its 1994 World Report on Women's Health, the Federation states that women's health is often compromised not by lack of medical knowledge, but by infringements on women's human rights.

The principle of liberty is key to notions of civil and political rights, while the principle of justice is key to notions of economic and social rights. The principle of equality is an

overriding one. Questions of distributive justice arise in relation to the tragic economic choices that go to the fair allocation of scarce resources and the setting of priorities, and here we often find discrimination against women in the low priority given to their special sexual and reproductive health needs. But many of the issues raised by this paper go to the attitudes of policy makers and of health care providers in relation to their clients, and to the fundamental notion of respect for human dignity and the right to reproductive autonomy, which are not essentially a matter of economic cost.

The discourse of human rights does not provide any ready made answers to the problems and dilemmas that arise in any given context. Human rights are not absolute values in the sense that they trump all other considerations. Indeed, in some instances the rights of one person may be in conflict with the rights of another. But rights are absolute in the sense that they must be taken into consideration and balanced against other interests. In making and implementing law and policy, and in the delivery of services, the rule should be that violations of human rights may be justified only as measures of last resort; after all other possible means to achieve desired goals have been exhausted. Where several measures present themselves as comparably effective, there should be preference for that which is the least detrimental alternative in terms of its effect on the enjoyment of human rights. The process of deliberating among possible alternatives in terms of their effect on human rights, increases our sensitivity to the compromises we make in reality while aspiring to an ideal world in which human dignity is the paramount value.

Recommendations

1. Increasing Public Awareness of Issues Relating to Reproductive Rights and Responsible Reproductive Behavior. In this case-

- Reproductive health education can be provided in a number of venues-homes, schools, mosque, other community settings, but must always be developmentally and culturally appropriate; and
- Taking knowledge level and emotional capability to discuss sexuality issues of different families, equity of access to information for promoting sexual health and responsible sexual behavior, is a vital component of community responsibility.

2. Providing the Health and Social Interventions Necessary to Promote and Enhance Reproductive Health and Reproductive Rights. In this case following measures can be generated-

- Eliminate disparities in sexual health status that arise from social and economic disadvantage, diminished access to information and health care services, and stereotyping and discrimination;
- Improve access to sexual health and reproductive health care services for all persons in all communities;
- Provide adequate training in sexual health to all professionals who deal with sexual issues in their work, encourage them to use this training, and ensure that they are reflective of the populations they serve;
- Encourage the implementation of health and social interventions to improve sexual health that have been adequately evaluated and shown to be effective;
- Ensure the availability of programs that promote both awareness and prevention of sexual abuse and coercion; and

- Strengthen families, whatever their structure, by encouraging stable, committed, and enduring adult relationships, particularly marriage.

3. Investing in Research Related to women Health and Disseminating Findings Widely. Following measures are thought to be important-

- Promote basic research in human sexual development, sexual health, and reproductive health, as well as social and behavioral research on risk and protective factors for reproductive health;
- Dissemination and evaluation of educational materials and guidelines for sexuality education, covering the full continuum of human sexual development, for use by parents, clergy, teachers, and other community leaders; and
- Expand evaluation efforts for community, NGO and clinic based interventions that address reproductive health and rights.

BIBLIOGRAPHY

Abraham M. (1999), "Sexual abuse in south Asian immigrant marriages", in *The Journal of Violence Against Women*, vol-3, June 1999.

Acton G (1992), "Comprehensive sexuality policy, procedures and standards", in Crocker A, Cohen H, Kastner T. [Eds.] *HIV infection and developmental disability*. Baltimore, Paul Crooks Publishers, p-133-139.

Akhter H H et al (1994), *Prevalence of Maternal Morbidity*, BIRPERHT-4, Briefing paper *Maternal morbidity in Bangladesh*, Vol- 1, Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies [BIRPERHT], Dhaka, Bangladesh.

Alauddin, M, 1982, *Maternal Mortality: A study of two Upazilas in Bangladesh*, Programme for the Introduction and Adoption of Contraceptive Technology, Bangladesh.

Alamgir S. F (1977), "*Profile of Bangladeshi women selected aspects of women's roles and status in Bangladesh*" prepared for USAID Mission, Dhaka, p. 58

Amanda Kolburn Kowal, and Lynn, Blinn-Pike, (2004), *"Sibling Influences on Adolescents' Attitudes toward Safe Sex Practices"*, Family Relations, Volume 53, Issue 4, pages 377–384, July 2004

Anderson JR (1987), "Why is Hum oral Medicine so popular?" Social Science and Medicine, Vol 25. No-4, pp 331-337, UK

"Applying the CEDAW Convention for the recognition of women's health rights" (2002), *ARROW's For Change*, Volume 8, No 1, Asian-Pacific Resource and Research Centre for Women [ARROW]. p- 12. Kuala Lumpur.

Azhar, B. S. et.al., 1998, "*Knowledge about iodized Salt Among middle class and retailers of Dhaka City*" in IDD Newsletter-3

Azhar, B. S. et.al (1998), Knowledge about iodized Salt Among middle class and retailers of Dhaka City in IDD Newsletter-3

APHA (1994), *"Reproductive health approach endorsed in draft of Cairo document"*, Anonymous, JOICEP News (240), Washington D.C Association, November 30.

Behrman, J. R, and A.B. Deolalikar (1983), Will increased Income Improve Developing Country Nutrition? A case for Rural South India. New work: The Population Council Research Note No-11

Beng Hui, T. 2007. Exploring the potential of the UN treaty body system in addressing sexuality rights. IWRAW Asia Pacific Occasional Papers Series, no.11,

Berer, Marge (ed.), (2000), "Reproductive rights, human rights and ethics". *Reproductive Health Matters*, Volume 8, Number 15, May 2000, Oxford: Reproductive Health Matters c/o Blackwell Science, p -197.

Bernhart M H and Uddin MM (1990), *Islam and family Planning Acceptance in Bangladesh*, University Research Corporation, Dhaka, Bangladesh, pp. 287-92

Berer, Marge (ed), (2000), "Reproductive rights, advocacy and changing the law". *Reproductive Health Matters, Volume 8, Number 16, November 2000*, Oxford: Reproductive Health Matters c/o Blackwell Science, p. 201.

Bergman, Y. (20040, *Breaking through: a guide to sexual and reproductive health and rights*, Stockholm: The Swedish Association for Sexuality Education (RFSU), p-64.

Boyden, J. (1996), *"Social and Cultural Meaning of Childhood"*, *Development* (the journal of the Society for International Development-SID), VII, I, Blackwell Publishers Ltd., Oxford and Cambridge, pp. 18-22.

Brewis A A. (1993), *Reproductive ethno physiology and contraceptive use in a rural Micronesian Population Providence Rhode island*, Population studies and Training Center (PSTC), Brown University.

Brent C. Miller, (2002), 'Family influences on adolescent sexual and contraceptive behavior", Journal of Sex Research, http://findarticles.com/p/articles/mi_m2372/is_1_39/ai_87080436/

Carol H and Carolyn F (1994), *"Anthropology and studies of Human Reproductive Medicine Anthropology and contemporary theory and Method"*, Edited by Thomas M Johnson and Carolyn F., Sargent, pp. 215

The Cairo Hearing on Reproductive Health and Human Rights, (1995), From Vienna to Beijing, *Center for Women's Global Leadership*, , New Brunswick, NJ.

Chowdhury, T. A (1996), *"Adolescent Reproductive Health"*, paper presented at the first Grid Workshop on situation Analysis on Adolescent Reproductive Health, NIPSOM, Dhaka.

Choudhury, Ahmed F. H. and Shaooli Mahboob (2003), *"Indigenous knowledge on Reproductive Health among Rural Women of Bangladesh"* Vol-11 no 2 & 3, pp. 50-61

"Conceptualizations of Sex among Young People in Malawi", January 2010, *African Journal of Reproductive Health*, Vol 11 (3), African Population and Health Research Centre, pp. 221-235. Available at http://www.bioline.org.br/abstract?id=rh07044&lang=en

Cornwall, A. & Welbourn, A. (eds), (2002), Realizing rights: transforming approaches to sexual & reproductive well-being, London, Zed Books, p- 322.

CREA 2006, Sexual rights and social Movements. CREA, New Delhi, p-28. *Available at* www.files.creaworld.org/files/wp.pdf

David A. Sack, *"Achieving the Millennium Development Goals for Health and Nutrition in Bangladesh: Key Issues and Interventions-An Introduction"*, HEALTH POPUL NUTR, 2008 September; 26(3), PP. 253-260, ICDDR,B, Dhaka, Bangladesh. Available at www.icddrb.org

Donohoe M T. (2006), *"Teen Pregnancy: A call for sound science and public policy"*, in *Current Controversies in Teen Pregnancy and Parenting*, Lisa Frick, (ed.), Farmington Hills, MI: Greenhaven Press/Thomson Gale,. pp-14-16, at http://zmagsite.zmag.org/Apr2003/ donohoe0403.html

"Ensuring young people's sexual and reproductive rights", *ARROW's For Change*, Volume 4, No 3, December 1998, Kuala Lumpur: Asian-Pacific Resource and Research Centre for Women (ARROW), p-12.

Fauzia Akhter Huda, Evelyn Ford, Aartee Deshpande, Nafis Al Haque, M. A. Quaiyum, Joan Healy, Karen Otsea, and Heidi Bart Johnston, *"Strengthening Health Systems Capacity to Monitor and Evaluate Programmes Targeted at Reducing Abortion-related Maternal Mortality"*, Reproductive Health Programme Working Paper No. 1, June 2010, ICDDR,B, Dhaka. Available at www.icddrb.org

Gardner, Rexanne (1995), Female Adolescent Health Care: International Perspective, in Benjamin. P Sachs, Richard Board, Emile Papiernik and Cristine Russel (ed.), *Reproductive Health care for Women And Babies*, Oxford University Press.

Hartman, B. (1995), Reproductive rights and wrongs: the global politics of population control, revised edition, Boston: South End Press, p- 388.

Hasan Mostafa, 2003, *"The State of Children and Child Development in Bangladesh: An Overview on the 1990s"*. HUMAN FACE. Vol-11 no 2 & 3, pp. 13-37.

Hawkins, K. & Price, N. (ed.), "The social context of sexual and reproductive health: a framework for social analysis and monitoring", Swansea: Centre for Development Studies, University of Wales.

Heise L L (1994) *"Gender- based violence and woman's reproductive health"*, International journal of Gynecology and obstetrics, Vol 46 (2), pp. 221

Heidi Bart Johnston, (2009), "*Relationships of Exclusion and Cohesion with Health:The Case of Bangladesh*", HEALTH POPUL NUTR, August 2009, vol 27(4), pp. 426-440, ICDDR,B, Bangladesh. Available at www.icddrb.org

Humble, M. (ed.) (1995), "Sexual and reproductive health and rights of women", *IPPF*, Discussion Paper Issue One, London: IPPF, p-19.

International Conference on Reproductive Health, (1998), Mumbai, India, at www.un.org/womenwatch/daw/csw/shalev.htm

IWHR (1994), *"Sexual and reproductive rights and health as human rights: concepts and strategies"*, at An Introduction for Activists International Women's Human Rights Law Clinic, New York, NGO Forum International Conference on Population and Development, Cairo, New York: IWHR, p- 75. *at* http://www.iwraw-ap.org/aboutus/pdf/OPS11Final_Publication_Version_February_27.pdf

Jalal, S., Ahmad, C. and Farzana, D. (2003), "*Anthropological Perspective on Adolescent Pregnancy*" *Nrvijnana Patrika*, Vol. 8 (2003), pp 102-111, Jahangirnagar University, Dhaka.

JOICFP (1995), Focusing on Reproductive Health for Adolescents, Anonymous, JOICFP NEWS, vol. (252):3.

Kabir, A.F.M.I and Bhuyan, M.A.H (1991), "*Background paper for the Workshop on Development of strategies for GOB/NGO Complementarily in Nutrition Programme for Women and Children in Bangladesh*", Voluntary Health service Society, UNDP, Dhaka.

Kariapper, R. (2007), "*Reproductive health and rights: unraveling realities Lahore, Karachi, Peshawar*", Women's Resource Centre, Shirkat Gah, p-66

Lee E (1994), "*Women's reproductive health*" in conveying concern: Women right on reproductive health, compiled by Population Reference Bureau, Washington, D.C

Litigating reproductive rights: using public interest litigation and international law to promote gender justice in India, (2006), Centre for Reproductive Rights, India.

Lindahl, K. & Bergstrom, M. (ed.), (1995), Sexual and reproductive health and rights in relation to the Cairo Conference: ICPD 1994, Stockholm: RFSU.

Maria de Bruyn, (2007), Women, Reproductive Rights, and HIV/AIDS: Issues on Which Research and Interventions are Still Needed, Policy Division, Ipas, USA, p.413–425, at-http://centre.icddrb.org/pub/ publication.jsp?ClassificationID= 30& pubID = 8293

Marge Koblinsky, Iqbal Anwar, Malay Kanti Mridha, Mahbub Elahi Chowdhury, and Roslin Botlero, *"Reducing Maternal Mortality and Improving Maternal Health: Bangladesh and MDG 5"*, HEALTH POPUL NUTR, September 2008, pp. 280-294, ICDDR,B, Dhaka, Bangladesh. Available at www.icddrb.org

MANOSHI, ICDDR,B Research Brief, Issue-4, September 2010. Available at www.icddrb.org

Mas'dar F. Mas'udi, (2008), Islam and Women's Reproductive Rights, translated into Bangla by Shahjahan Faruque, The Asia Foundation, Dhaka.

Misra G. & Chandiramani, R. (eds), (2005), Sexuality, gender and rights: exploring theory and practice in South and Southeast Asia. New Delhi, London: SAGE Publications. p-313.

Miller, (1998), "Family influences on adolescent sexual and contraceptive behavior", Journal of Sex Research, Feb, 2002 at available *http:// findarticles.com /p*/articles/mi_m2372/is_1_39/ai_87080436/

Morsheda Banu, Shamsun Nahar and Hashima-E-Nasreen, (2010), "Assessing the *MANOSHI* Referral System: Addressing Delays in Seeking Emergency Obstetric Care in Dhaka's Slums", January 2010, Manoshi working paper, ICDDR,B and BRAC, Dhaka, Bangladesh. Available at www.icddrb.org

Mtimarvalye L (1994), "Reproductive Maternal morbidity: Prevention of high risk Pregnancies and deliveries" (Unpublished) p. 19

Nichter, M and M. Nichter (1982), The Ethno physiology and Dietetics of Pregnancy: A case study from south India, Human Organization, vol. 42(3), pp. 235-246.

Preamble to the Constitution of the World Health Organization (1946), as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Rahman S., Nesa F., Rahman S., Ali R. & Ali H. Ara (1989), *"Reproductive Health of adolescent in Bangladesh", Internation Journal of Gynecology & Obstetrics*, pp. 29:329

Rosalind P. Petchesky, (2000), *"Reproductive and Sexual Rights: Charting the Course of Transnational Women's NGOs"*, June 2000, United Nations Research Institute for Social Development (UNRISD), Geneva, Occasional Paper No. 8.

Rimon JG, Tweedie I., (1994), "Men are from mars, Womem are from Vanus: Male involvement in reproductive health", (Unpublished) p-7.

Sabiha B, (1993), Reproductive of pregnancy wastage with gravidity, pregnancy order and age of mother, *Dissertation*, DMCH and FP, NIPSOM, Dhaka.

"Strengthening community participation and accountability in sexual and reproductive health and rights", (2003), *ARROW's For Change*, Volume 9, N. 3, 2003. Kuala Lumpur: Asian-Pacific Resource and Research Centre for Women (ARROW), p -12.

Statistical Pocket Book of Bangladesh, (1995), Bangladesh Bureau of statistics, Statistics Division, Ministry of Planning, Dhaka.

The Free Dictionary, at http://medical-dictionary.thefreedictionary.com/ health.

Transforming Health Systems: Gender and Rights in Reproductive Health, (2001), a training manual for health managers, published by World Health Organization, Department of Reproductive Health and Research, at http:// www.who.int/reproductivehealth/publications/ genderrights/ RHR_01_29/en /index.html

UNFPA, (1995), "Guidelines for UNFPA Support for Reproductive Health, Including family Planning and Sexual Health, UNFPA.

UNFPA, (1995) "Health in Poverty: potentials to Orchestrate Health and Poverty Interventions in the Context of Basic Health Services Package Under HPP-V", WHO, Bangladesh.

UNFPA, (1995) "Review of Selected Pilot project/Interventions in Health and Population Sector" Ministry of Health and Family Welfare, GOB

UNFPA, (1995) "Reproductive Health and Family Planning Program: Status, Issues and Constrains", Prepared for the Seminar on Implementation Population Policies: Quality of Reproductive Health Care as the Way Forward, Kuching, Malaysia.

UNFPA, (1994) "Report of Expert Consultation on Reproductive Health and Family Planning Khan, N.I.

Universal Declaration of Human Rights, at www.un.org/Overview/rights. html

International Committee on Population and Development Plan of Action, (paragraph 7.3), at www.un.org/overview/rights/conference.html

WHO, (1991), The Reproductive Health of adolescent: A strategy for Action, a joint WHO/ UNFPA/ UNICEF statement, Geneva.

Williams, Fiona. (2007), Realising sexual rights, Institute of Development Studies. p- 56. *Available at:* www.ids.ac.uk/ids/part/proj/sexrights.html

Women's health and human rights: Monitoring the implementation of CEDAW, (2007), published by World Health Organization, Department of Reproductive Health and Research, *at* www.who.int/reproductivehealth/ publications /gender_ rights/ 9789241595100/en/index.html

Annexur-1
Figures

Figure-1

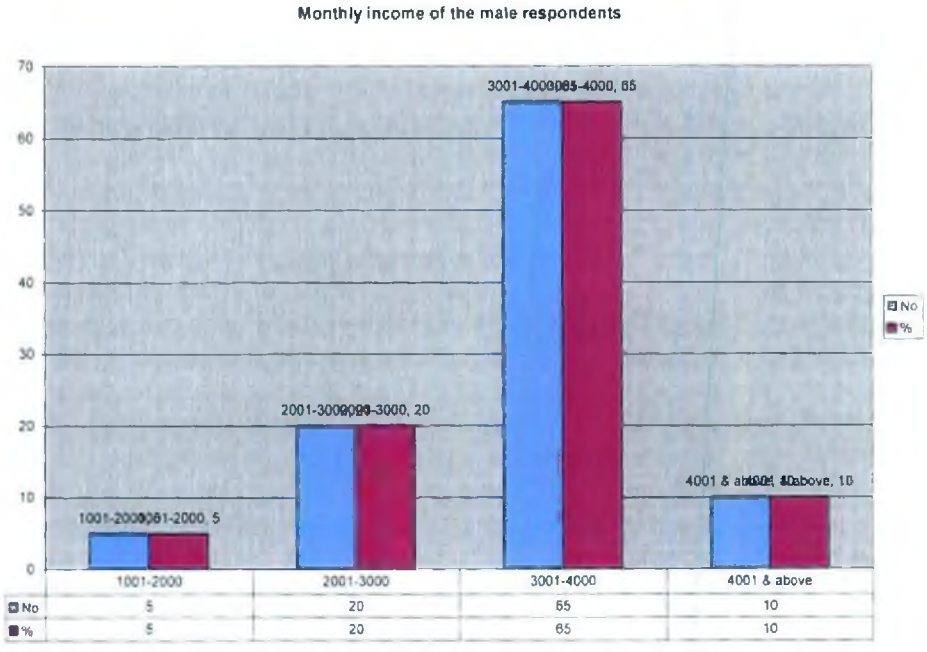


Figure-2

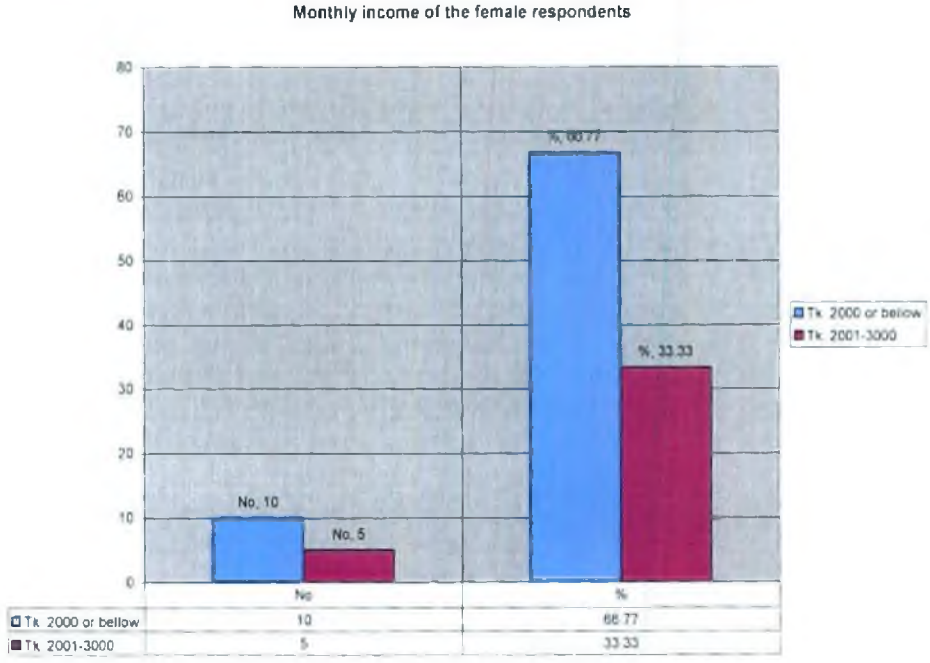
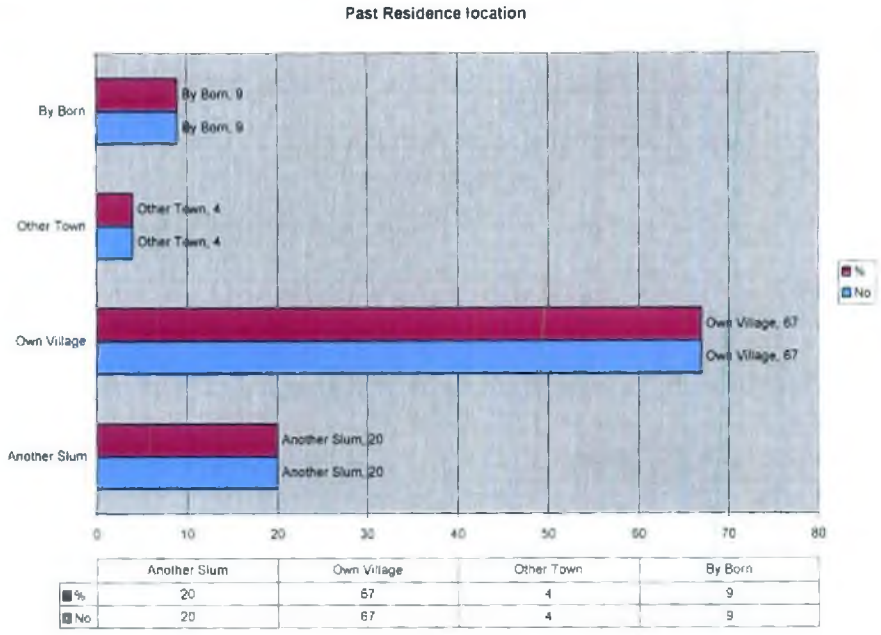
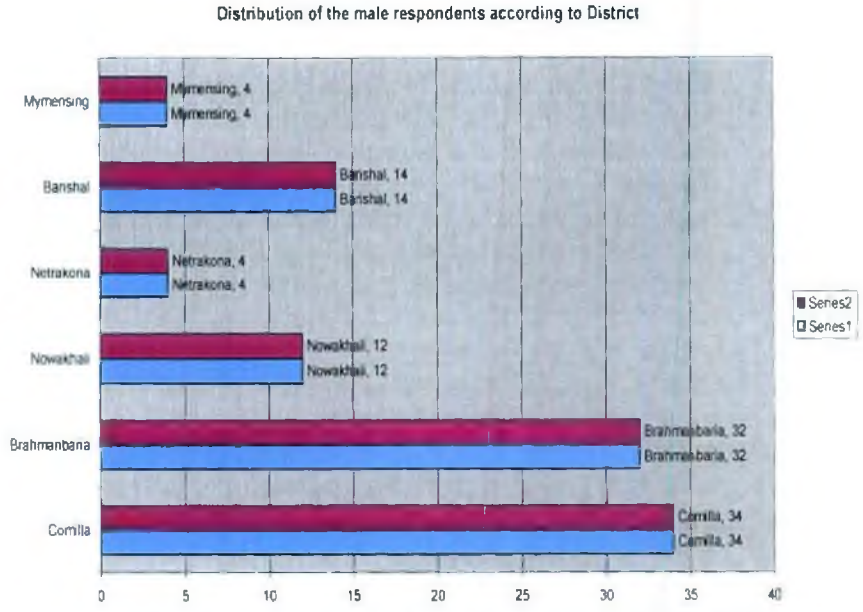


Figure-3



	Another Slum	Own Village	Other Town	By Born
%	20	67	4	9
No	20	67	4	9

Figure-4



	Comilla	Brahmanbaria	Nowakhali	Netrakona	Banshal	Mymensing
Series2	34	32	12	4	14	4
Series1	34	32	12	4	14	4

Figure-5

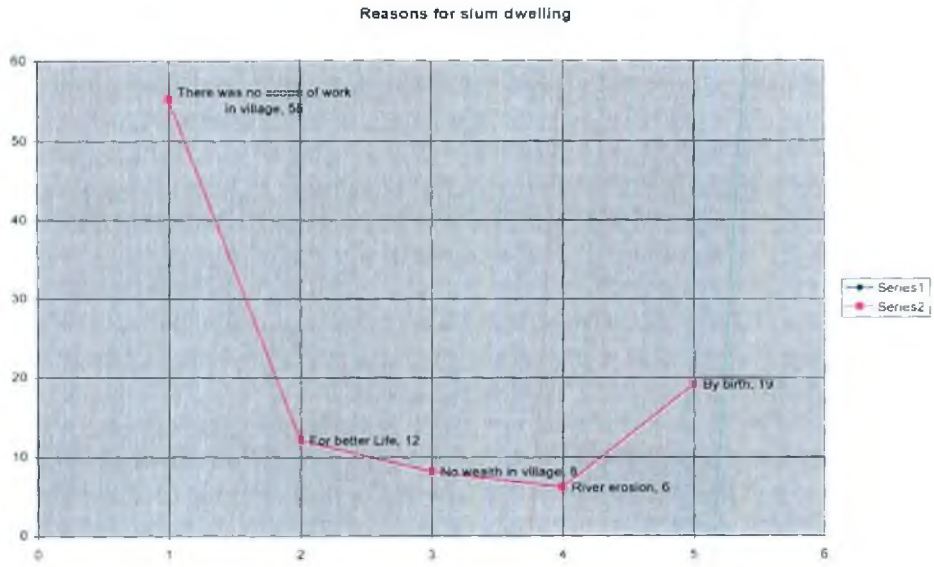
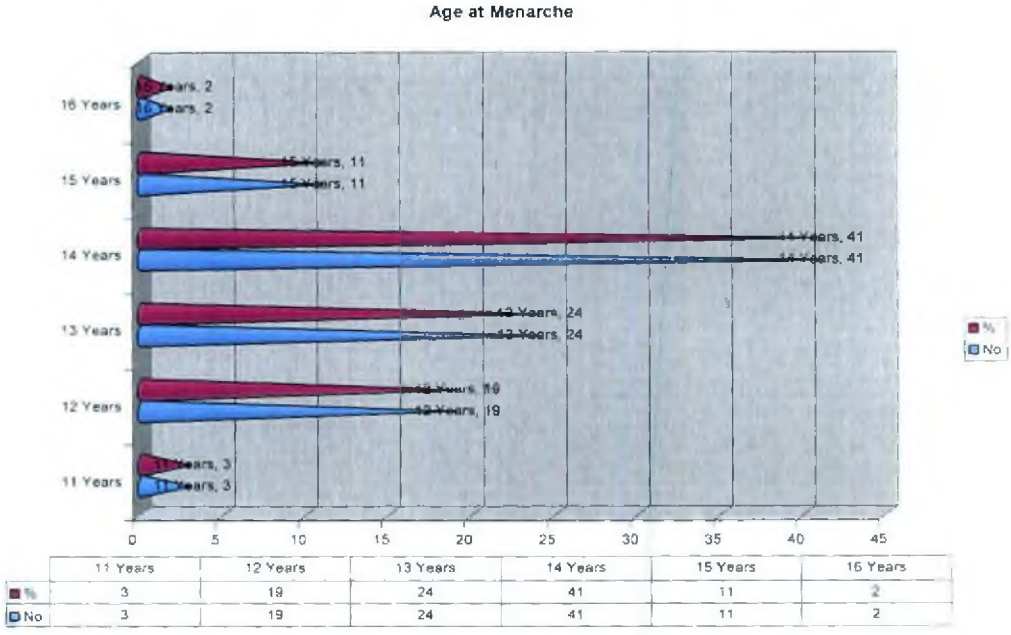
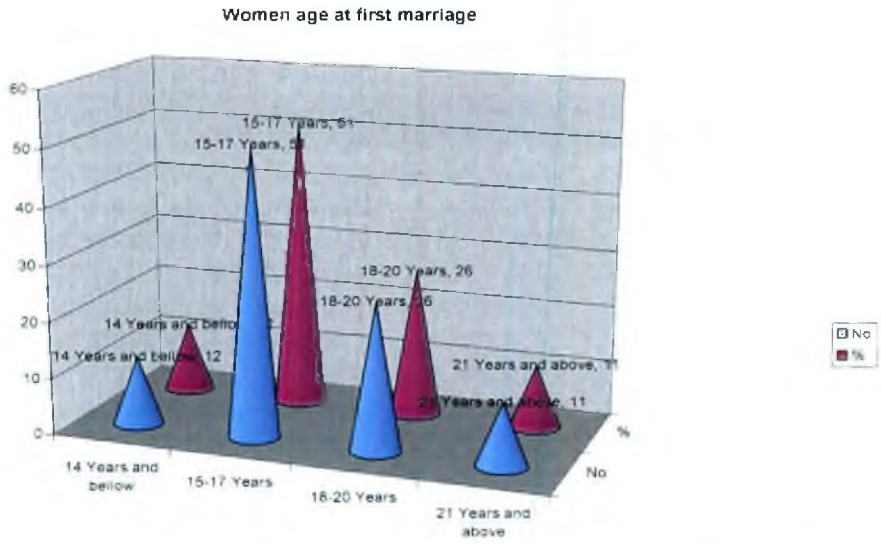


Figure-6



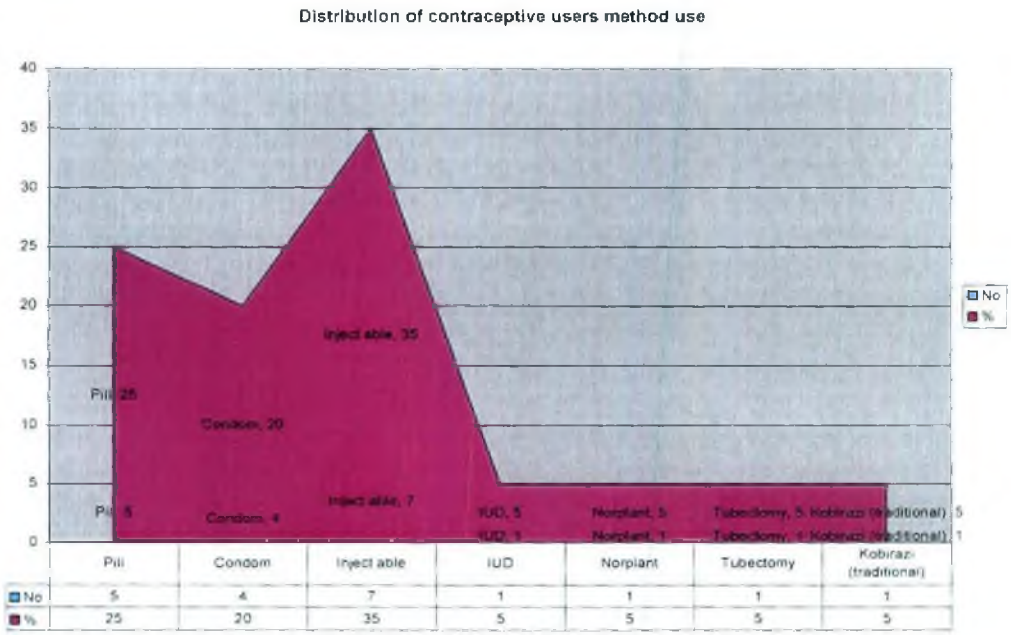
	11 Years	12 Years	13 Years	14 Years	15 Years	16 Years
%	3	19	24	41	11	2
No	3	19	24	41	11	2

Figure-7



	14 Years and bellow	15-17 Years	18-20 Years	21 Years and above
No	12	51	26	11
%	12	51	26	11

Figure-8



	Pill	Condom	Inject able	IUD	Norplant	Tubectomy	Kobirazi (traditional)
No	5	4	7	1	1	1	1
%	25	20	35	5	5	5	5

Figure-9

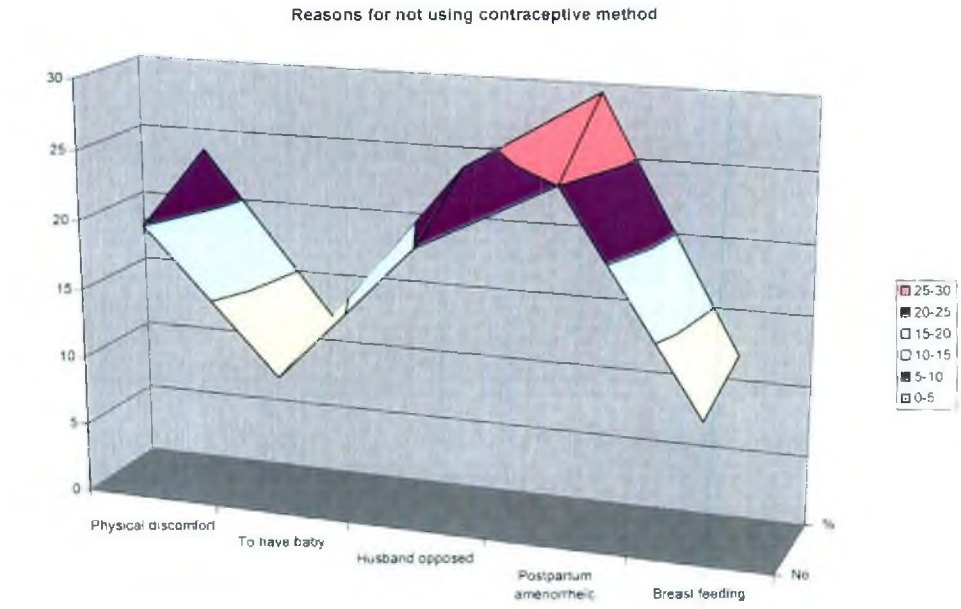


Figure-10

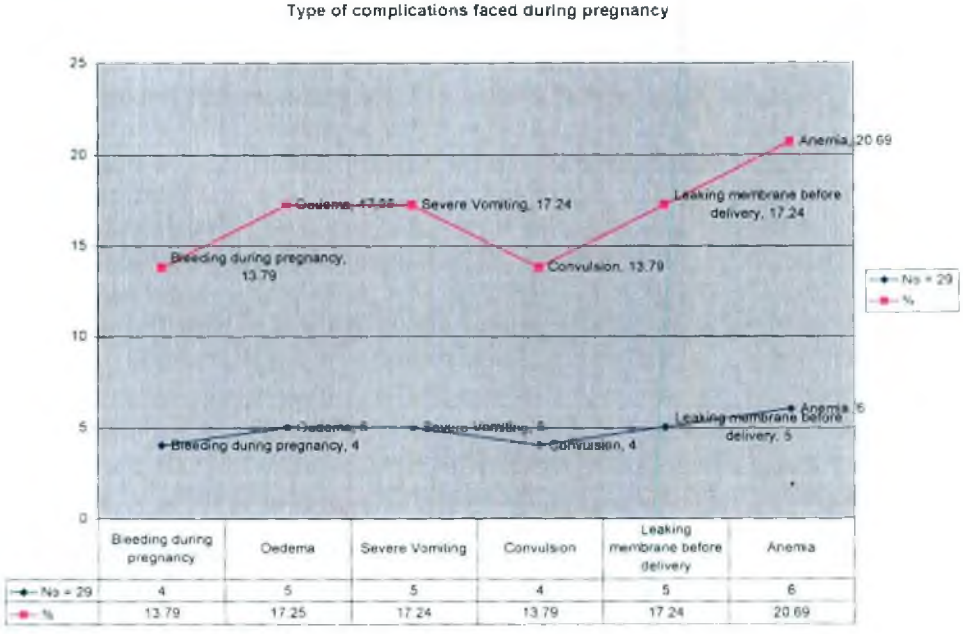
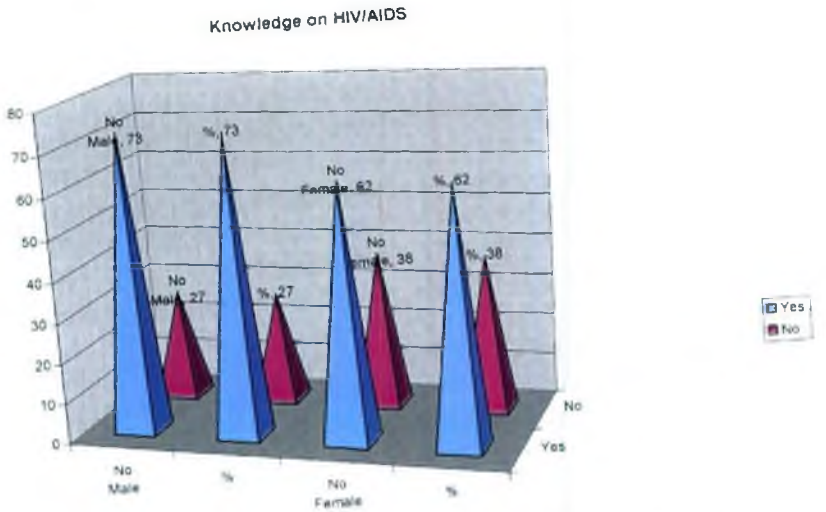


Figure-11



	No Male	%	No Female	%
Yes	73	73	62	62
No	27	27	38	38

Annexure-2
Questionnaire

বস্তির পরিচিতি ঃ

বস্তির নাম ঃ - - - - - - - - - - - - - - - - - জমিদারের নাম ঃ - - - - - - - - - - - - -

মহল্লার নাম ঃ - - - - - - - - - - - - - - - - ওয়ার্ড নং - - - - - - - - - - -

১। উত্তর দাতার পরিচিতি নং

২। আপনার নাম কি ?

৩। আপনার স্বামীর নাম কি ?

৪। আপনার বয়স কত ?

৫। আপনার ধর্ম কি ? ক) মুসলিম খ) বৌদ্ধ গ) খৃষ্টান ঘ) অন্যান্য

৬। আপনি কোন শ্রেণীতে পড়াশুনা করছেন ? ক) নিরক্ষর খ) প্রাথমিক গ) মাধ্যমিক ঘ) স্নাতক ঙ) অন্যান্য

৭। আপনি গৃহের কাজ ছাড়া অন্য কোন কাজ করেন কি? ক) কিছু করে না খ) গার্মেন্টস শ্রমিক গ) আয়া/বুয়া ঘ) বাঁশ বেতের কাজ ঙ) সেলাই চ) অন্যান্য

৮। আপনার মাসিক আয় কত?

৯। ঘরের ধরণ ক) কাঁচা খ) সেমি পাকা গ) পাকা

১০। ল্যাট্রিনের ধরণ ঃ ক) আধুনিক ল্যাট্রিন খ) সেপটিক ট্যাংক গ) জলাবদ্ধ ল্যাট্রিন ঘ) খোলা ল্যাট্রিন

১১। আপনাদের পরিবারে যারা বর্তমানে এই বস্তিতে একত্রে বসবাস করছেন তাদের মোট সংখ্যা কতজন ?

১২। আপনি (প্রথম) কত বৎসর বয়সে বিবাহ করেছেন ?

১৩। আপনি কত বৎসর যাবৎ বিবাহিত ?

১৪। প্রথম সন্তান জন্মের পর আপনার বয়স কতছিল ?

১৫। আপনার বর্তমানে ছোট সন্তানের বয়স কত মাস ?

১৬। বর্তমানে ছোট বাচ্চার সঙ্গে পূর্বের বাচ্চার বয়সের ব্যবধান কত ? প্রযোজ্য নয়

১৭। আপনি কি বর্তমানে গর্ভবতী ক) হ্যাঁ খ) না

১৮। (উত্তর হ্যাঁ হলে) আপনি কত মাসের গর্ভবতী ? মাস

১৯। বর্তমানে আপনি কোন পরিবার পরিকল্পনার পদ্ধতি ব্যবহার করছেন?
ক) না খ) খাবার বড়ি গ) আই.ইউ.ডি ঘ) নর প্ল্যান্ট ঙ) ইনজেকশন ছ) আজল

২০। নিয়মিতভাবে ব্যবহার করছেন কি? ক) হ্যাঁ খ) না

২১। শেষবার কোথা থেকে জন্মনিয়ন্ত্রন পদ্ধতি গ্রহণ করেছেন ?
ক) ঔষধের দোকান খ) মুদি দোকান গ) হাতুড়ে ডাক্তার ঘ) সহকারী ক্লিনিক

২২। বর্তমানে কোন পরিবার পরিকল্পনার পদ্ধতি ব্যবহার না করলে তার কারণ কি ? ক) সন্তান লাভের আশায় খ) স্বামীর আপত্তি গ) শারীরিক অসুবিধা ঘ) পার্শ্বপ্রতিক্রি য়ার ভয়ে ঙ) ধর্মীয় কারণে চ) বুকের দুধ খাওয়ানোর মাসিক বন্ধ

২৩। আপনি অতীতে কি পদ্ধতি ব্যবহার করেছিলেন ক) করেন কি খ) কনডম গ) বড়ি ঘ) কপারটি ঙ) আজল চ) ইনজেকশন

২৪। কতদিন যাবৎ ব্যবহার করেছিলেন

২৫। ভবিষ্যতে কোন পদ্ধতি ব্যবহারের ইচ্ছা আছে কি? ক) ইচ্ছে নেই খ) কনডম গ) বড়ি ঘ) কপারটি ঙ) নরপ্লান্ট চ) ইনজেকশন

২৬। পরিবার পরিকল্পনা পদ্ধতি সম্পর্কে স্বামীর সাথে আলাপ আলোচনা /পরামর্শ করেন কি? ক) হ্যা খ) না

২৭। (উত্তর না থাকলে) স্বামীর সাথে আলোচনা/পরামর্শ না করার কারণ কি?

২৮। গভ গর্ভকালীন সময়ে স্বাস্থ্য সেবা বা চেক-আপ করিয়েছেন কি? হ্যাঁ খ) না

২৯। সর্বশেষ বার কোথা থেকে বা কার কাছ থেকে সেবা নিয়েছেন? ক) এনজিও ক্লিনিক খ) এম.বি.বি.এস. ডাক্তার গ) হাতুড়ে ডাক্তার ঘ) নার্স

৩০। সন্তান প্রসবের বা ডেলিভারীর কয় দিন/কয় সপ্তাহ/কয় মাস পূর্বে সর্ব শেষ বার কোন ডাক্তার বা ক্লিনিক গিয়ে স্বাস্থ্য সেবা নিয়েছেন এবং তখন সঙ্গে কে ছিল?

৩১। আপনি গত গর্ভকালীন কসয়ে কয়টি .টি.টি (ধনুষ্টংকার) ইনজেকশন নিয়েছেন?
ক) একটিও না খ) ১ ডোজ গ) ২ ডোজ ঘ) ৩ ডোজ
৩২। সর্বশেষ গর্ভকালীন অবস্থায় আপনাকে বাড়তি/বিশেষ ধরনের খাবার দেওয়া হয়েছিল কি? ক) হ্যাঁ খ) না
৩৩। কি কি বিশেষ/বাড়তি খাবার খেয়েছেন?
খাবারের ধরণ ঃ নিয়মিত মাঝেমধ্যে
৩৪। শেষ গর্ভকালীন সময়ে কি কি খাবার পরিহার করেছিলেন?
খাবারের ধরণ ঃ পরিহারের কারণ
৩৫। শেষ গর্ভকালীন অবস্থায় আপনাকে বাড়তি বা বিশেষ খাবার না দেওয়ার কারণ কি?
৩৬। আপনার এই সন্তানটি কোথায় হয়েছিল।
ক) হাসপাতাল/ক্লিনিক খ) স্বামীর বাড়ী গ) বাপের বাড়ী ঘ) অন্য কোন স্থান
৩৭। কে আপনার এই সন্তান প্রসস করিয়েছেন ? ক) এম.বি.বি.এস. ডাক্তার খ) নিকট আত্মীয় /দাই/প্রতিবেশী গ) প্রশিক্ষণ প্রাপ্ত দাই ঘ) স্বাস্থ্য
৩৮। আপনার এই সন্তানটি কত মাসের সময় হয়েছিল ? ক) ৭ মাস খ) ৮ মাস গ) ১০ মাস
৩৯। আপনার এই সন্তানটির আকার কেমন ছিল? ক) ছোট খ) মাজারী গ) বড়
৪০। সন্তান প্রসবের পর পর শালদুধ বাচ্চাকে দিয়েছেন কি? ক) হ্যাঁ খ) না
৪১। উত্তর নার হলে কেন দেওয়া হয়নি ? প্রযোজ্য নহে।
৪২। এই সন্তানকে শুধুমাত্র বুকের দুধ না দেওয়ার কারণ কি ? ক) হ্যাঁ খ) না
৪৩। সন্তানকে বুকের দুধ না খাওয়ানোর সময় আপনাকে বাড়তি খাবার দেওয়া হয়েছে কি? ক) হ্যাঁ খ) না
৪৪। খাবারের ধরণ ঃ নিয়মিত মাঝেমধ্যে
৪৫। সন্তান প্রসবের ৪২ দিনের মধ্যে আপনি কি কোন প্রসবোত্তর সেবা গ্রহণ করেছিলেন? হ্যাঁ না
৪৬। উত্তর হ্যাঁ হলে কার কাছ থেকে না কোথা থেকে সেবা গ্রহণ করেছেন?
ক) এনজিও ক্লিনিক /হাসপাতাল/সেটেলাইট খ) হাতুড়ে ডাক্তার গ) কবিরাজ ঘ) এম.বি.বি.এস ডাক্তার